Appendix IV

Monterey County Mental Health Services Act

Innovation

Annual Evaluation Report

FY 2021-22

Micro-Innovation Grant Activities for Increasing Latino Engagement Innovation Plan

Annual Evaluation Summary Final Report

January 2023

EVALCORP
Measuring What Matters℠

MONTEREY COUNTY BEHAVIORAL HEALTH
Avanzando Juntos Forward Together

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Introduction

Monterey County Behavioral Health (MCBH) created the Micro-Innovation Grant Activities for Increasing Latino Engagement Innovation Plan (Micro-Inn). The Micro-Inn project is designed to uncover effective approaches to improve the outreach for and delivery of mental health services to the underserved Latino population in the county. The three-year project was extended to five years, partly due to the COVID-19 pandemic. The project, which is funded with Mental Health Services Act Innovation funding, began in 2018 and ends in August 2023.

MCBH contracted with EVALCORP to evaluate the impact of the Micro-Inn project. EVALCORP's engagement in the evaluation began in August 2022. This report includes program-related information, as well as an overview of the evaluation methods and findings through June 30, 2022.

Micro-Inn Project

The Micro-Inn project was created to address the problem of relatively low numbers of Latinos utilizing behavioral health services in the county. The program intended to address this problem by enabling a diffuse network of micro-innovation activities designed specifically by and for local communities, neighborhoods, niche cultural or ethnic sub-groups, etc. The activities could be a one-time activity or a sustained activity not to exceed 12 months. To implement this Innovation project, MCBH created a grant application, scoring criteria (Appendix A), and the Micro-Innovation Grant Review Board to score the applications. MCBH also created a referral tracking form for grantees to utilize in their programs (Appendix B).

The main learning goal of this project is to determine if any of these micro-innovation activities are effective in engaging Latino populations with needed mental health services. Specific learning goals of this project are:

- For each micro-innovation, identify how many Latino individuals received a referral for mental health treatment who have never engaged with mental health services.
- For each micro-innovation, identify how many Latino individuals followed through on a referral and received mental health treatment services.
- Identify if the total count of Latinos served increased during this innovation project.
- Identify if any micro-innovation activities demonstrate capacity for sustainability in impact and/or funding.
- Identify if and how cultural barriers were addressed.

Table 1 presents the evaluation questions for the Micro-Inn Program, which are aligned with the project learning goals established for the initiative, and the associated data source. Results from focus groups with grantees are not included in this report as the focus groups have yet to be conducted.

Table 1. Evaluation Questions and Data Sources

Evaluation Questions	Data Source
For each micro-innovation, how many Latino individuals, who have never engaged with mental health services, received a referral for mental health treatment services?	Grantee Evaluation Reports
For each micro-innovation, how many Latino individuals followed through on a referral and received mental health treatment services?	Grantee Evaluation Reports
Did the total count of Latinos served increase during this innovation project?	Grantee Evaluation Reports
Did any micro-innovation activities demonstrate capacity for sustainability in impact and/or funding?	Grantee Evaluation Reports and Focus Groups
How were cultural barriers addressed?	Grantee Evaluation Reports and Focus Groups

The grantees were required to maintain the following records:

- Total client count
- Demographics
- Count of individuals who have not received mental health services previously
- Number of referrals
- Type of referrals
- Number of referrals where individuals followed through on an appointment

During FY21/22 there were three rounds of applications (rounds four, five, and six). Rounds one, two, and three were completed in prior fiscal years and are not included in this report. Ten out of 16 applications received were funded. An overview of funded projects that are included in this report are summarized in Table 2. Six projects were denied during FY 21/22 (Table 3). The reasons for denial included: activities were inconsistent with the intent or requirements of the innovation plan or applications were missing several necessary components to explain the implementation and evaluation plan. Full descriptions of approved and denied applications are in Appendix C.

Table 2. Funded Projects FY 21/22

Awardee/Program Name	Funded Amount Requested/Expenditure Implementation Period	High-Level Description
Round 4 (Completed Projects)		
Michael Houston/Greenfield Cultural Arts Events Outreach (Mi Via, Mi Arte, Mi Alegria)	$5,850/$6,728 February – June 2022	The project hosted a booth and provided culturally attuned entertainment with a mental health focus at cultural fairs in south county for migrant farmworker communities.
Door to Hope/Circle of Security Program for Farmworkers	$50,000/$50,000 June 2021 – May 2022	The project adapted and provided the Circle of Security (COS) classes and case management activities in Spanish and Triqui to underserved and unserved migrant farmworkers and Indigenous communities. The COS program aimed to promote secure child-parent attachment relationships.
MILPA/Rancho Cielo Youth Leadership Training	$50,000/$50,000 July 2021 – June 2022	The project focused on serving the youth, primarily Latinos, at Rancho Cielo Youth Campus, a comprehensive learning and social services center for underserved youth in Monterey County. Culturally relevant mental health support and services are provided to system-impacted youth under the Telpochcalli umbrella. In the structured virtual setting, Telpochalli took intake referrals, implemented services, and referred participants to MCBH mental health services.
Emeralda Owen/Public Service Announcements	$50,000/$50,000 July 2021 – May 2022	The project provided monthly public service announcements (PSAs) in Spanish for Spanish language television and radio stations, plus quarterly interview hour on Spanish language radio.
Round 5 (Completed Projects)		
Monterey County Public Health Bureau (MCPHB)	$50,000/$36,166 August 2021 – June 2022	The project developed an education plan to address youth mental health needs at Alisal and Everett Alvarez High Schools in the Salinas Union High School District. The plan involved training a minimum of 30 peer educators through the Mind Matters™ curriculum, hire of a public health student intern, and a reach of 1,000 students through classroom presentations. Education

		and referrals to local mental health services were made available over the course of implementation activities.
NAMI*	$22,300/$0	The Monterey County chapter proposed the implementation of a program to support undocumented Spanish speaking residents in seeking mental health services. The program was supposed to include a series of five Spanish-only presentations in neighborhood venues.
Community Human Services	$50,000/$50,000 October 2021 – September 2022	The project was a collaboration with the Monterey County Office of Education's Migrant Education Program to facilitate mental health workshops to parents and students.
Round 6 (Projects Currently Implemented)		
Door to Hope	$50,000 July 2022 – June 2023	The project added a tri-lingual therapist to the Greenfield school district, where high amounts of migrant farmworker children are enrolled, to better serve them and their families.
United Way Monterey County (UWMC)	$50,000 September 2022 – January 2023	The project involved training Promotores to use the UWMC's Smart Referral Network tool. The project is in partnership with Boys and Girls Club Monterey.
Precious Stone PR, Inc.	$50,000 June 2022 – May 2023	The project created monthly novella-style, Spanish-language PSAs to broadcast on local Spanish language television stations.

* The applicant withdrew interest prior to entering into agreement with MCBH due to lack of staff capacity.

Table 3. Denied Projects FY21/22

Applicant/ Program Name/Amount Requested	High-Level Description
Round 4	
Jorge Rojas/ Monterey County Soccer Club/$50,000	A local soccer-league organization proposed to help the soccer community receive necessities and mental health resources. The applicant planned to develop a team trained in mental health care services to serve the 6,000 members of the soccer organization. The proposal focused on building trust by providing members with basic needs (e.g., food, water, shelter, clothing). Once the basic needs were met, the plan was to offer information on mental health services and referral information.
Rocio Quintero/Gonzales Citywide Outreach	The Gonzales Unified School District and city of Gonzales proposed a project for the local Latino/a community to engage in mental health services through various activities. These activities included painting classes, support groups, and calming corners.
Emeralda Owen/Precious Stone PR, Inc.	The proposed project was a digital marketing idea that involved the creation of digital content and graphic designs to disseminate information about mental health services in Monterey County.
Round 5	
California State University Monterey Bay (CSUMB)	A student at a local university proposed focus groups, facilitated by CSUMB physician's assistant students, for migrant farmworkers in south Monterey County. Focus groups would include a curriculum of tools including mindfulness, meditation, and decentering. These tools were intended to help farmworkers cope with mental health issues until they were able to see their provider.
AIM Youth Mental Health	A local youth-oriented non-profit proposed a plan for a participatory action research pilot program to extend mental health education, prevention, and intervention with high-school students, youth counselors, parents, and youth-serving organizations in Monterey County. The goal was to engage youth in mental health conversations, build advocacy, raise awareness, and educate youth on evidence-based solutions. This project sought the participation of youth aged 14-18, with an emphasis on serving English as a second language students and those living in poverty.
Round 6	
Majesh Natrajan	The sound healing (singing bowls) was intended to introduce holistic, mindfulness-based sound meditation treatment practice in Monterey County to relieve symptoms of mental health issues. It would be done with an immersive on-demand multi-sensory meditation pod-like structure, called "Heal". Heal uses sound therapy as the "training wheels" for a strong foundation of long-term meditation practice that enables participants to be mindfully engaged.

Evaluation Methods

The Micro-Inn evaluation is designed to answer the learning and evaluation questions posed for the project and includes both qualitative and quantitative data collection strategies. Data utilized for the evaluation were from reports submitted by grantees who completed their projects during FY21/22. Five grantees submitted reports; one was still outstanding (MILPA /Rancho Cielo Youth Leadership Training) at the time of writing this report. The remaining projects are in progress, and therefore, evaluation reports have not been written by those grantees.

Limitations

As with any evaluation, the Micro-Inn assessment confronted limitations imposed by circumstances. The EVALCORP team was not involved in the evaluation for the first four years of the project. Due to challenges in capturing data, only one of the grantees submitted referral data and two submitted demographic data. Some project impacts, such as those from PSAs, cannot provide information about the number reached or those who received services as a result of the program. Lastly, projects included in Micro-Inn may take time to influence the seeking out of mental health services and the impacts may show in longer-term evaluations.

Findings

Referrals to mental health services among the Latino population was one on the main goals of the Micro-Inn project. Door to Hope (n=32) was able to capture referral data to show that approximately one-third (38%, n=12) of participants were referred to mental health services; nine participants were successfully connected to mental health services and continue to see their therapist regularly. Other referrals were made as well, including parent education, food banks, financial assistance, etc. Two programs tracked demographic information and four were able to track reach (Table 4).

Table 4. Reach and Demographics by Project, FY 21/22

Project Name/Program Cost	Reach	Demographics
Mi Via, Mi Arte, Mi Alegria/$6,728	285 attendees at six events	*Ethnicity (n=129)** 86% Mexicano/Mexicana (n=112) 34% Latin American (n=44) 6% Indigenous (n=8) 5% White (n=6) *Age in Years (n=87)* 20% 0-12 (n=17) 8% 13-20 (n=7) 29% 21-35 (n=25) 44% 36+ (n=38) *Gender (n=94)* 59% Female (n=55), 41% male (n=39) *Could select more than one response item
Door to Hope/$50,000	32	100% Hispanic/Latino
MILPA/Rancho Cielo Youth Leadership Training/$50,000	Report Pending	Report Pending
Emeralda Owen/$50,000	Unknown	Unknown
Monterey County Public Health Bureau/$36,166	For the Mind Matters program, 65 peer educators were trained and 77 presentations were completed; peer educators reached 1,740 unduplicated youth. Postpone program, a teen pregnancy program, reached 1,000 youth. Social media analytics were not available.	Unknown
Community Human Services/$50,000	Estimated 208,760	Unknown

Summary of the Project Outcomes and Impacts of Each Project

Mi Via, Mi Arte, Mi Alegria. The grantee, located in south county, used community artist performers to share experiences to counter attitudes of stigma associated with mental health

issues. Recognized community artists promoted access to mental health services in a safe, family-appropriate environment. The live performances allowed artists to share their lived experiences with mental health challenges and recovery. The project audience and presenters consisted of Oaxacan and Spanish-speaking farmworkers, and individuals residing in Monterey County in Salinas, Greenfield, and King City. The events included dialogue with the audience about topics such as the value of art as healing, the value of joy in dance, the importance of artistic social activities for children, and how music saved a singer from depression after an injury as a farmworker in Greenfield. Poetry, songs, and dances were included.

The grantee created a survey that was disseminated at each event. Attendees completed the survey, which asked for information regarding demographics, unhappiness, and the value of social services in Spanish. The purpose of the survey was to assist respondents in determining if they should seek service referrals for mental health services for themselves, their friends, or their families. Ninety-four percent of respondents (n=141) stated they would attend another event in the future. When asked if they have friends or family who are unhappy, 35 out of 121 respondents (29%) selected the "yes" response option and 100% (n=82) answered that they would like help in Spanish with social services.

Evaluation perspectives. The program was well attended (n=285) and had a low cost for the relatively high reach. It has the potential to be self-sustaining. The activities had strong cultural components and included recognized members of the community. In general, the Latino population is a story-telling culture, which is expected to have resonated with them.

Door to Hope. The organization provided the Circle of Security eight-week classes and case management services. Four eight-week sessions were provided. The program is group-based, and about 10 parents participated in a two-hour weekly virtual group meeting for eight weeks. Two facilitators and a care coordinator attended each meeting. Twelve referrals were made to mental health services (three to access line, six to Community Human Services non-insured mental health program, one to Beacon Health, one to Door to Hope's Behavioral Health Integrated Program, and one to a private insurance provider). Nine participants were successfully connected to mental health services and continue to regularly see their therapist. Other referrals made include parent education, food banks, financial assistance, etc.

"Offering Circle of Security classes to the unserved and underserved Latino communities was a fundamental way to begin exploring basic mental health components and information with a population that has limited access to mental health education or resources."

- Circle of Security Program Administrator

The participants shared the following statements indicating that they reflected on and analyzed what they learned in the sessions:

- "I used to yell at my daughter when she'll cry, and she would cry even more, but now when I speak softly to her and try to understand her with questions, she'll calm down."
- "My daughter likes to explore a lot, I thought she was naughty but now I know she just wants to learn."
- "I have hate in my heart because of how I was treated as a child by my parents. And sometimes I feel like I'm doing the same with my children and I'm afraid of losing them."

Evaluation perspectives. The program was successful at making referrals, and the curriculum is culturally relevant. The program is impactful for parents and their relationships with themselves and their children. The program could be self-sustaining if participants are charged a cost to participate that is not prohibitive to those who have low-income.

Emeralda Owen/Public Service Announcements. Twelve monthly PSAs related to mental health were delivered in Spanish. No information was provided about the potential reach or impact of the announcements.

Evaluation perspectives. The program impact cannot be determined due to lack of data. The program is not expected to be self-sustaining even if the ads are delivered at no cost due to the expense of developing them.

Monterey County Public Health Bureau. MCPHB delivered two programs: Mind Matters and Postpone. The Mind Matters and Postpone curriculums and trainings were purchased from The Dibble Institute. Mind Matters was implemented to help youth overcome adversity and build resilience. Mind Matters has been used by other agencies to prevent violence, address chronic absenteeism, and build a culture of wellness. Postpone, a teenage pregnancy prevention program, provided training, education, and resources in the areas of mental health and teen pregnancy prevention services. The program's goals and outcomes are in Table 5.

Table 5. Goals and Outcomes

Goals	Outcomes
Train a minimum of 30 high-school students at Alisal and Everett Alvarez High Schools and one college level student intern to serve as peer educators.	Sixty-five peer educators were trained.
Reach 1,030 students from Alisal and Everett Alvarez High Schools through classroom presentations.	Seventy-seven presentations were given to 1,740 students.
Refer into services 10% of youth reached (103 youth based on the original goal).	Unable to accurately track this number.

Successes associated with this project included initiating conversations and sharing information with youth about mental health and seeking mental health services. The programs provided a safe space for youth to hear about and normalize the topic of mental health. Some youth

shared their own experiences, and this reminded other students that mental health issues are common, and that support is available.

Peer educators stated they really liked the Mind Matters content. The information they learned was shared with others via social media posts, and during one-on-one conversations with students. Peer educators also reported that they were using the information learned to help their siblings and friends. Peer educators learned to identify some of the signs, such as declines in school performance, poor grades, constant anxiety, social withdrawal, or aggression, which may indicate the need for mental health services. The Mind Matters curriculum assisted not only our Postpone peer educators but also facilitators and students across all our teen pregnancy prevention programs to clear away barriers. The curriculum helped to build skills in the educators that transferred to others through one-on-one interactions.

Postpone peer educators completed one-on-one outreach to their peers, documented their interactions, and posted positive messages about accessing mental health services, tips on mental health, and mental health resources to their personal social media accounts (e.g., Instagram, Snapchat). Posts were intended to reduce stigma and increase the understanding of mental health resources and services. Teens often go to other teens for help on topics such as reproductive health, homework, employment, etc. The Postpone program used a peer education model and students received accurate information and resources from their peers. Postpone peer educators were assigned to classrooms to speak on topics such as depression, anxiety, and mental health to normalize discussing mental health services and to increase the likelihood that the youth in the classrooms will seek mental health services.

Evaluation perspectives. The program engaged students in discussions about mental health and could potentially lead to greater help-seeking behavior among our youth. The cultural relevance is related to having the peer model. Peers have similar generational cultures and are from the same community. The cost of the curriculums would be a one-time fee, and there is a fee for the participant's journal. These items could be incorporated into the school budget, and the program could be sustained. The evaluator is uncertain if the journals are required to deliver the program.

Community Human Services. The organization facilitated workshops about mental health in collaboration with Monterey County Office of Education's Migrant Education Program (MEP), disseminated materials, and delivered radio announcements. The topics were:

- No cost mental health services for uninsured or those with Medi-Cal (for parents)
- Tricolor Radio "Free Mental Health Counseling" Spots
- Workshops (five) on mental health topics for parents and students
- Tricolor radio stations in a "Lunchtime Giveaway" promotion to disseminate mental health information and free mental health services to Monterey County Latino/migrant families and farmworkers
- Mental health gift packs were disseminated at the Artichoke Festival on June 11, 2022, and during both days of the Salinas Rodeo on July 21 and 22, 2022.
- Facebook mental health and cross-promotional ads ran from June 1 through September 30, 2021; ad impressions: 539,000; ad reach: 151,000.

Their outreach for quarter one (when they shared materials about mental health) had an estimated reach of 600 people, the quarter two public radio announcement reached 55,400, quarter three workshops' (five) reach was estimated at 800, and for quarter four, the activities at festivals and events reached approximately 960 people. The grantee also ran Facebook ads that reached 151,000 people in four months.

Evaluation perspectives. The reach was high for these activities. The impact cannot be determined with the data that are available.

Discussion

In this section of the report, the topics of reach, referrals, sustainability, and culturally tailored programs are addressed.

Reach. The projects reached their intended audience, which was the Latino population, based on the limited demographic data available. The media and radio ads had a wide reach as well as the performing arts program. The Circle of Security classes for parents offered by Door to Hope had a smaller reach but resulted in several referrals to mental health and other services. The MCPHB programs had a significant reach to youth. The Community Human Services program had a significant reach as well.

Referrals. The data on the number of referrals for those that have never engaged with mental health services, the number who followed through with the referral, and the total count of Latinos served during this Innovation project is relatively unknown as the information is available for only one program (the Door to Hope program resulted in 12 referrals to services with 28% [n=9] of attendees continuing to regularly see a therapist). It is possible that these projects had an impact on the mental health of the intended audience. The programs may have encouraged participants to engage in activities to assist with prevention or early intervention of mental health challenges. In addition, they may have opened the door to considering treatment in the future or engaging family and friends to participate in activities that promote mental health or seek help for themselves.

Sustainability. With regards to sustainability, the performing arts program was cost efficient in terms of dollars spent and reach. It has the potential to be self-sustaining. Tickets to the event could be sold at a reasonable cost, and it is possible to have the entertainers perform pro bono and possibly have venues donate or provide space at a low cost. More rigorous evaluation strategies are needed to assess their impact on the attendees in terms of perspectives on mental health, ability to implement improvement strategies, and service seeking. The Door to Hope Circle of Security classes, while appearing to be effective, were expensive ($50,000) for the number reached (n=32; average of eight per eight-week session course). The other programs had greater reach for the same amount or less money. It may be worth examining if the Circle of Security classes can be more cost efficient. The MCPHB programs are offered at schools and could be incorporated into the school budget. The cost is not prohibitive.

Culturally tailored. The programs utilized a variety of methods to address cultural barriers, including language. The Mi Via, Mi Arte, Mi Alegria incorporated lived experiences of how Latinos overcame barriers and incorporated dialogue about mental health. The program included culturally rooted stories, poems, and music. The Door to Hope program explored what a person already knows or has experienced around positive relationships, so the organization was able to learn the different practices parents already use to process mental health challenges. For example, cultures and communities already have mental health ideas and rituals and now need spaces in their new communities in Monterey County to practice their native traditions that help them heal their mind and body. When people have resources in their communities that reflect who they are and where they come from, they are more willing to accept help and support when they need it.

"…we learned that the Triqui community historically participates in 'sweat lodge' like rituals when needing to heal their body and spirit. They also have leaders that guide a person through going back to painful memories or experiences that 'robbed' them of their positive spirit and process those negative experiences to bring their positive spirit back to them."

– Circle of Security Program Administrator

The MCPHB programs were culturally relevant as they used a peer approach. The peers are of the same age, generational culture, school, and community. Being from the same school and community likely means that there are cultural similarities in terms of one or more of these factors: race, ethnicity, age, socio-economic status, and geography.

Recommendations

Recommendations are related to tracking referrals, additional evaluation of promising practices, the quality of the Behavioral Health referral number, and the school referral process. MCBH is not able to make some of these changes, but perhaps they can make recommendations to the appropriate individuals.

Tracking referrals. This was challenging for several reasons, including shame, fear, embarrassment, and stigma. In addition, a participant may not seek services as they have learned ways to self-manage their mental health issue through the program or the participant may seek services in the future, which would be difficult to track.

Another reason that tracking referrals is challenging is related to anonymity and confidentiality around referrals and appointments. Door to Hope stated that youth did not wish to share, even with the peer educators who they had built relationships with, any information about accessing behavioral health services. Students recommended implementation of services that would allow youth to access care and support anonymously, if possible. Students were concerned about the confidentiality of their information/record, similar to the concerns students have when staff make referrals to Family Pact clinics for medical appointments. Students are concerned about who will have access to their record, specifically if a parent will be able to access their record. More education and information services are needed by students on the

right to privacy when seeking behavioral health services.

The recommendation is not to use referrals as a basis for evaluating program impacts due to the challenges of tracking them. Other metrics are encouraged to be used.

Promising practices. The Mi Via, Mi Arte, Mi Alegria, Door to Hope Circle of Security, and Postpone and Mind Matters programs have shown promise, yet it is not possible to determine the true impacts of the programs with the limited data. It is recommended to conduct additional assessments of these programs in the future if feasible. For the Circle of Security program, an analysis is needed to determine the cost of an eight-week course.

Behavioral health referral number. One grantee reported that during follow ups, some youth reported hearing from other youth of "bad service" when calling the behavioral health referral number. No additional detail was provided on this. Due to the context of the discussion, the program believes this information could have stemmed from the students who were asked for identifying information by the person answering the behavioral health phone. In other words, students may have felt discouraged to seek help by having to provide their identifying information. Other students reported that they received the help they needed when calling the behavioral health number, yet it was unclear when they had called and if services were sought during the project timeline. It may be of value to explore the quality and practices of the behavioral health assistance. The same grantee shared that students reported confusion about the referral and intake process, and did not understand whether they should call back or if someone would call them back.

In addition, peer educators in the Postpone program reported that several students indicated they were more comfortable seeking services at the school (e.g., school wellness center) rather than calling a behavioral health clinic, because they did not know who would be on the other end of the telephone line and feared they would be judged.

One grantee noted that staff learned that to become more responsive to this population, there must be a more instant way to refer students directly to an on-call professional. Youth recommended a referral number that is dedicated to teens and can be accessed via text (the benefit they reported would be receiving immediate support, which "wouldn't be as scary as calling and talking to someone"). Although crisis text lines are available to youth through national and state resources, staff and peer educators were unaware of local text options for youth who are seeking ongoing mental health support in a non-crisis situation. A local text option for teens is highly recommended.

School referral process. Students shared concerns and confusion over school procedures/policies regarding how to access behavioral health or counseling services. Students shared that different schools seem to have different procedures. Students also expressed concern over "extra and unnecessary hurdles" such as a requirement to see their school counselor before they are "allowed" to go to the wellness clinic or other mental health support person (at one school). Increased information on the role of a school guidance counselor in the high schools and their role in making referrals to behavioral health is recommended. Some

students who shared information with peer educators also stated intake forms were challenging to complete.

Summary

Micro-Inn intended to lead to referrals to mental health services among the Latino population. For the most part, the evaluation did not have ability to assess if referrals occurred due to the available data, yet insights to lessons learned and recommendations were gained. The programs reached a large number of people and a couple of potential promising programs were identified. An in-depth evaluation of the promising programs is needed.

Appendix A: Grant Application Form and Scoring Criteria

Application for Micro-Innovation Grant

Monterey County Behavioral Health (MCBH) is currently offering a funding opportunity for one-time projects that may increase the engagement of Latino communities with our local mental health services system. For several years, health record data for Monterey County has indicated Latino communities to be the most underserved in our county. Extensive community feedback has indicated this may be due to current services not resonating with the various Latino ethnicities, languages and dialects, and cultural norms that exist across our large county. In response to this feedback, MCBH has obtained Mental Health Services Act (MHSA) Innovation funding to support individuals and organizations across Monterey County to try out their own unique approach to promoting mental health services in ways that better reach their Latino ethnicity, culture, language, city, neighborhood, etc. As a result, it is hoped that more culturally appropriate and impactful mental health service delivery and communication methods will be uncovered.

MHSA Innovation funding is intended for testing out new "out-of-the-box" ideas that can improve our mental health system. These projects can test out a new practice or approach to delivering mental health services, adapt an existing mental health service to better serve a group of people, or promote better communication and collaboration between agencies and organizations to make services more accessible and/or provide better quality services. It is not necessary for these projects to demonstrate success (although that's desirable!); but rather, it is most important to learn from the successes and failures of the ideas to better inform the mental health services community on best practices.

Micro-Innovation Application Requirements:

1. All activities must be new! Innovation funds are dedicated for testing new and novel concepts and may not be used to supplement existing programs or activities.
2. Eligibility: All members of our community are encouraged to apply, including members of the public, past and current clients, affected family members, students, community partners and service providers.
3. Budget: Activities may be small or large in scope, with budgets ranging from $500 to $50,000. Please note that funds received must be reported to the IRS as personal income and recipients will receive a 1099 tax form at the end of the year to assist in tax preparation.
4. Timeline: Activities may be a one-time event or a continuous activity lasting up to one year. Timelines should account for planning for the activity, implementing the activity, and organizing activity information for evaluation efforts.

Applications Rating Criteria:

A. Level of Innovation – Creativity and unique solutions to address community-specific needs is encouraged.
B. Evaluability – Being able to articulate the work to be done and the anticipated results of that work is very important, as it allows evaluation to occur on impact and cost-effectiveness.
C. Scalability – It is desirable for projects to be able to support an increased number of clients/participants
D. Population to be served – Projects will be awarded additional points for serving communities identified as most in-need, including zip codes with the majority of residents who are Latino, Spanish-speaking individuals, and Latino adults and older adults.

To assist in developing a strong application, the following documents can be referenced on the Monterey County Behavioral Health MHSA webpage (http://www.co.monterey.ca.us/government/departments-a-h/health/behavioral-health/mental-health-services-act):

- Scoring criteria
- Monterey County Behavioral Health Bureau Health Equity Report FY17/18
- Innovation Plan: Micro-Innovation Grant Activities to Increase Latino Engagement

Successful applicants will be contacted by MCBH and scheduled to meet with the Micro-Innovation Grant Review Board to refine project details as needed, prior to approval of funding.

The current deadline for submitting applications is April 15, 2019. Applications received after this date may be considered for the next application period to be held in Fall 2019.

Questions may be sent to MHSAinnovation@co.monterey.ca.us

1. Contact Information

Name:_____ Phone Number:_____

E-mail Address:_____

2. Population of Interest

a. Who do you plan to serve? (i.e., specific Latino/Hispanic ethnicity, language, culture, neighborhood, etc.)

_____
_____
_____
_____
_____

b. What issue do you hope to address?

_____
_____
_____
_____
_____

c. How many individuals to you expect to serve?

_____
_____
_____

3. Project Methodology

d. What idea do you want to test?

_____
_____
_____
_____
_____

e. How will you do this? (i.e., what work will be involved, who will do it, where and when will it happen, etc.)

4. Evaluation

f. What would it look like if your project was successful? How will you know?

5. Budget

Please list the costs and explanation of costs associated with this project:

	Cost ($)	Explanation of Costs
Estimated Labor Costs		
Estimated Materials Costs		
Other costs		
Total Request		

6. Timeline

g. What is the timeline for carrying out this project?

_____
_____
_____
_____
_____

Micro-Innovation Application Scoring Criteria

Does the application identify a unique and underserved Hispanic/Latino target population to be served by the micro-innovation activity?
1 – Target population is described in broad terms (no specific features related to ethnicity, language, region of residence, etc.; e.g., only "Latinos in Monterey County")
3 – Target population is identified by unique characteristics (one or more characteristics are identified, e.g., "Mono-lingual Spanish speakers", "Oaxacan farmworker communities", "LGTBQ Latinos in Salinas", etc.)
5 – Target Population is identified by unique characteristics, and it is apparent this population is not or cannot be adequately served by existing mental health services in Monterey County (supporting research is provided)

Does the application clearly identify a barrier to accessing care, that is unique to the identified target population?
0 – Barrier to accessing care is not unique to Hispanic/Latino populations.
1 – Barrier to accessing care is unique to language / communication challenges (i.e., This barrier is easily overcome by translating materials)
3 – Barrier to accessing care is unique to ethnicity, cultural history and/or trauma, geographic region in Monterey County, or another specific characteristic. It is unclear if, currently, the local mental health services system has no solutions to the identified barrier.
5 – Barrier to accessing care is unique to ethnicity, cultural history and/or trauma, geographic region in Monterey County, or another specific characteristic. It is clear that, currently, the local mental health services system has no solutions to the identified barrier.

Is the proposed solution offered through the micro-innovation unique and innovative?
Note: when using the word 'solution', this is in reference to solving the stated barrier to accessing care for the target population. As these micro-innovations are a form of pilot or research project, the 'solution' is the intervention being delivered to the target population through some product/service treatment.
0 – The application presents a solution that is not unique and innovative (e.g., "to hire more Spanish-speaking therapists", providing group therapy or informational sessions, media outreach such radio commercials)
1 – The application presents a solution that is innovative for Monterey County (i.e., it is clear the proposed solution is not currently being offered anywhere in Monterey County.
3 – The application presents a solution that is unique and innovative for the community at-large, where it is apparent that the proposed product/service has never been tried before.
5 – The application presents a solution that is unique and innovative, and is specific to engaging, connecting, and motivating clearly defined underserved population(s).

Does the project have a clear strategy to engage/connect with its target population?

0 – No, it is unclear how the target population will be reached and/or engaged to participate.
3 – Yes, it is clear how the target population will be reached and/or encouraged to participate.
5 – Yes, it is clear how the target population will be reached and/or encouraged to participate. Additionally, the proposed project can be safely implemented during the current COVID-19 pandemic (e.g., a plan for socially distanced activities is provided, or the project can be implemented virtually).

Does the application have a clear plan for providing and monitoring referrals to mental health services?
0 – The proposal does not include a clear strategy or plan that describes how the 2 following evaluation elements will be recorded: 1) The number of mental health service referrals generated by the micro innovation, and 2) the number of individuals that accessed care (i.e., followed up on a referral) as a result of this micro-innovation.
5 – The proposal does include a clear strategy or plan that describes how the 2 following evaluation elements will be recorded: 1) The number of mental health service referrals generated by the micro innovation, and 2) the number of individuals that accessed care (i.e., followed up on a referral) as a result of this micro-innovation.

Does it appear, through the project description and proposed timeline, that impacts of this micro-innovation (i.e., individuals accessing services) can be observed within 12 months of the start-date?
0 – No
3 – Yes

Are the costs included in the proposed budget justified?
0 – No
3 – Yes

Applications will not be considered if they score any 0 items, if unamenable. Competitive ranking for all scoring applications.

Appendix B. Referral Form

Client Name: _____

Contact Information:
_____

Date of Referral: _____

Please list name of agency/programs referred to: *(if more than one, list all)*	**Did this person participate at least once in the services of the agency/program that you referred them to?** *(mark 'X' on applicable response)*		
	Yes	**No**	**Unable to Determine**
1.			
2.			
3.			
4.			
What racial/ethnic categories do they identify with?:	○ American Indian or Alaska Native ○ Asian ○ Black or African American ○ Hispanic or Latino ○ Native Hawaiian or Pacific Islander Native Hawaiian or Pacific Islander ○ White ○ Multiracial ○ Another race/ethnicity: _____		
What language do you speak at home?:	○ English ○ Spanish Another language: _____		

Tear off below line for client:

Behavioral Health Resource Referrals

Agency/Program	Contact Information

Appendix C: Project Descriptions (Unedited)

Completed Project Descriptions (Unedited)

Round 4

Michael Houston/Greenfield Cultural Arts Events Outreach

Population of Focus

U.S. Census data indicates that 19.24% of families and individuals in South County and Greenfield are below the poverty line and struggling to attain self-sufficiency. Social and economic inequalities in culturally and linguistically diverse Hispanic/Latinx and indigenous communities in Greenfield and South Monterey are manifest in many ways. Income insecurity causes stress that impacts physical and mental health yet that community receives proportionately less mental health services than other demographic groups in the county. As we build healthier communities we need to mitigate poverty and health issues. Solutions are complicated by language and cultural factors. MCBH has indicated that communications for available services are not resonating with Hispanic/Latinx ethnicities and language groups in Greenfield and South Monterey County. In FY2016/17, Latinos made up 75% of the Medi-Cal eligible population in Monterey County, yet were only 53% of MCBH mental health service consumers.

The solutions begin at the community level to strengthen the connections between the community and health and social service providers. We propose engaging underserved families and individuals in Greenfield through arts programs that stress the value of accessing mental health services.

The program raises community consciousness to take positive ongoing action for positive mental health service outcomes among low-literacy, monolingual, bilingual, and multilingual farmworker families across generational lines. Program performances will be developmentally and culturally appropriate for every age group. The artist participants will be a sustainable culturally competent cadre for years to come.

Problem to be addressed

In the Greenfield community, there is a shortfall in predictable mental health services. There is a cultural disconnect between the community and the service providers. We need a micro innovation of consciousness-raising arts program led by artists from the Greenfield community to make the case for accessing mental heal services in Latinx Spanish, Indigenous, and bilingual populations. Artists from the Greenfield community need to act as a bridge between individuals and families and mental health services. Artists from Greenfield's agricultural and marginalized Latino/Hispanic community can connect more with Spanish and Oaxacan language, speaking. The Greenfield community has a rich artistic tradition in which children are raised in a tradition of dance, music, and spoken word arts. Well-attended events like the Fourth of July, Harvest Fest, Día de los Muertos, and Las Posadas document the diverse community's willingness to participate in the arts. The Greenfield arts community can help the community connect to the caseworkers and mental health services. Community arts thrive in a community, which finds itself threatened by social forces that reject the community's culture. The community arts have an entry into the diverse community cultures that include, religious beliefs, curanderas, and folk tradition.

A culturally rich program of shared performances, food, and discussions can mitigate fear and stigma too often associated with mental health services. We offer a safe comfortable inclusive family environment to discuss the value of accessing mental health services in the context of a participatory community celebration.

In these celebrations of the arts and well-being members of the Latino/Hispanic community can go beyond seeing the mental health services for others and see when it benefits them. In relaxed frank discussions, these same people concede that financial stress, overcrowded housing, youth incarceration, school issues, medical expenses, fear of ICE, etc. impact their sense of happiness and well-being. Our community art-as-healing approach in ongoing arts programs in a non-mental health setting can improve trust in the mental health service delivery system.

Proposed Micro-Innovation Activity
Greenfield Arte y Bienestar 2021 is a community collaboration by relevant local Spanish speaking artists and cultural performing acting community trauma and resilience leaders. Over four weekends in October and November Greenfield Arte y Bienestar 2021 will put on a series of comidas y presentaciones, food and a show. The cultural programs will consist of four Oaxacan, Spanish, and English language performance art, dance, and music productions including meet the author events, peer-to-peer discussions, and delicious meals Mexican held at the Greenfield Art and Cultural Library and the Greenfield library. As we prepare for the performances we will also connect with the families of the two youth Greenfield dance troupes, Arcoiris Cultural, folklorico group, and Azomali Danza Azteca, Aztec dance.

The program will perform at community events with artists presenting their work to respectfully help Latinos overcome denial and pride that could prevent them from addressing their wellness needs.

The two authors' readings at the Greenfield Library and tabling at community events will include book raffles and giveaways by local Greenfield connected authors with personal experiences of the benefits of mental health services when going through personal and family crises.

Performances and reading will be followed by an informal discussion and high-quality culturally appropriate meals. All activities will conform with the city, county, and state Covid 19 health guidelines.

The presentations will be videoed for presentation on public access television and web sites. The videos will be a long-haul help to educate Spanish and Oaxacan language viewers in Monterey County to understand the importance of finding the health services they need to achieve physical and mental wellness.

Communication and Engagement Strategy
Shared food and cultural meaningful arts experiences can bring people together. Culturally relevant community artists and performing groups with deep roots in the agricultural community can connect members of the Latino/Hispanic community of Greenfield. They can share personal experiences that validate the value of mental health services. They make the case that art improves the quality of one’s life and helps heal. Art teaches us discipline which teaches us new ways of seeing. Community artists can use their own experience to explain that Spanish speaking caseworkers in Behavior Health help heal. In an unthreatening, our performing artist shares good culturally appropriate food and a good show with the community. They are promotores of well-being who share their art and stories with appropriate literacy leveled materials. They create situations of meaningful communication to promote the acceptance of formal and informal neighborhood, city, county, and state services. The positive artistic consciousness-raising process promotes better communication and collaboration between agencies/organizations and the community.

Our innovative mini-project Greenfield Arte y Bienestar 2021 is designed to meet the mental health access needs of the Spanish Speaking Salinas Valley community.

Evaluation Plan
Low-literacy surveys will identify how many Latino individuals that have never engaged with mental health services received a referral for mental health treatment services. Surveys will identify how many Latino individuals followed through on a referral and received mental health treatment services. Surveys to count of Latinos served increased during this Innovation project. Ongoing surveys will identify language preference - Spanish, triqui, mixteca, English).

Surveys ask participants about their sense of well being, possible likely of getting help for a friend, relative of services in Spanish, After how would you help a friend you thought might need emotional support Greenfield Arte y Bienestar 2021 will demonstrate its success by the number of participants who become applicants for Spanish-speaking program manager service and referrals for mental health services.

How many individuals do you plan to serve or reach with your micro-innovation activity?
600

How many individuals do you plan to refer to mental health services?
300

Door to Hope/'Circle of Security' Program for Farmworkers
Population of Focus
Door to Hope (DTH) will increase access to mental health services to a vulnerable population within Monterey County by adapting the evidenced-based practice Circle of Security (COS) to better serve underserved and unserved migrant farmworkers and Indigenous communities. Through the Micro-Innovations grant, DTH will assist in breaking the barriers and challenges Non-English-speaking individuals face in Seaside, Jolon, Greenfield, King City, San Ardo, San Lucas, San Miguel, Lockwood and Bradley. DTH has formed trusting relationships within these communities and has adapted to their needs offering documents, materials, activities and the sharing of information in Spanish, Triqui, and English.

Immigrants comprise over 30% of the total population in Monterey County and many families within this community have relocated from Mexico. They are experiencing mental health problems, trauma related issues, and continue to face daily challenges. Migrant farmworkers and indigenous communities experience physical stress at work, coupled with mental stress from family separation, documentation status concerns, and insecurity of work opportunities. As a result of poor wages, farmworkers routinely struggle against poverty and, because of their mobility and often due to language and cultural differences, they often feel a lack community support. Trauma endured before, during, and after migration, the struggles with behavioral and mental health concerns including post-traumatic stress disorder (PTSD), anxiety, stress, depression, substance abuse, and/or suicidal ideations pose an immediate threat to their mental health. It is important to consider the unique challenges and lifestyles of this population when it comes to their care, including how we address their mental health needs.

Problem to be addressed
DTH has the mission and the motivational capacity to break the barriers and challenges migrant farmworkers and indigenous communities face seeking mental health services. Trust, shame, and cultural taboos compound the language, transportation, employer-related scheduling conflicts, financial and affordability restraints. Families feeling unwelcomed and excluded, treated without respect or concern and the perception that undocumented members of the community are excluded from services are major challenges. Monterey County has the highest percentage of non-citizens of any California

County. These are some of the many barriers and challenges preventing underserved and unserved communities from accessing mental health services.

The majority population being Hispanic/Latino, Spanish is the most common language spoken at home (47% of the households in Monterey County). However, many from the indigenous communities speak neither English nor Spanish. Information and technology challenges within these communities are apparent and DTH continues to bridge this gap with bi-lingual and tri-lingual staff and open office hours at the Greenfield Community Center. DTH assists community members with documents, technology, translation services, and referrals to community agencies.

Mental illness within the community is highly stigmatized and keeps families and individuals silent. Men, women and children are reluctant to speak about mental health issues they may be experiencing. The fear of emotional concerns being dismissed, the stigma around mental health, and the fears of mental health issues being discussed outside the home weigh heavily on families and individuals. The reluctance to reach out for mental health services is often out of fear of the unknown. Providing access to early intervention services such as Circle of Security will build awareness, trust and confidence within these communities. Creating culturally sensitive spaces will allow parents to begin exploring what mental health means to them and for some this will lead to referrals in mental health services for more specialized support. Bi-or-tri-lingual Circle of Security Care Coordinators will reduce the disparities in order to build the relationships within the community and will result in increased identification and mental health service delivery.

Proposed Micro-Innovation Activity
1. What product/service is your micro-innovation providing to this population of focus to address the barrier(s) described above?

With the Micro-Innovations grant DTH will adapt and provide the Circle of Security (COS), engagement, and case management activities in Spanish and Triqui to the underserved and unserved Migrant farmworkers and Indigenous communities in Seaside, Jolon, Greenfield, King City, San Ardo, San Lucas, San Miguel, Lockwood and Bradley.

COS is an internationally recognized intervention/prevention program for parents. The COS program has aimed to promote secure child-parent attachment relationships. Its main goal is to translate decades of university-based attachment research into a user-friendly format for parents to learn how to provide both secure bases and safe havens for their children.

Program Summary
§ Provide outreach, engagement, and warm welcoming services through community stakeholder referrals.
§ The COS program is group-based: Parents will participate in 1½-hour group meetings once a week for 8 weeks with 15-20 other parents.
§ Week 1: Welcome to Circle of Security Parenting
§ Week 2: Exploring Our Children's Needs All the Way Around the Circle
§ Week 3: "Being 'With' on the Circle"
§ Week 4: Being with Infants on the Circle
§ Week 5: The Path to Security
§ Week 6: Exploring Our Struggles
§ Week 7: Rupture and Repair in Relationships
§ Week 8: Summary and Celebration

§ Provide case management services and referrals to improve individual and family functioning and mental health for participants in COS.

These sessions will be co-facilitated by members of the indigenous community for the indigenous community. Sessions will be tailored to meet the scheduling, language and cultural needs of these communities. Parents are invited to identify and reflect on the child's needs throughout each session surrounded by a supportive presence of fellow community members and DTH Care Coordinators. DTH's bi- and tri-lingual capacity will expand understanding to the indigenous-speaking communities. Videos in Spanish will be used extensively to promote parental reflection on parent/child interactions. Once mental health concerns are identified our COS Care Coordinators will guide families through the referral process and through individualized case management services we will assure families are connected to the resources they need to continue exploring their mental health needs.

The overall goals of COS:
• Increase security of attachment of the child to the parent.
• Increase parent's ability to read child's cues.
• Increase empathy in the parent for the child.
• Decrease negative attributions of the parent regarding the child's motivations.
• Increase parent's capacity to self-reflect.
• Increase parent's capacity to pause, reflect, and chose security-promoting caregiving behaviors.
• Increase parent's capacity to regulate stressful emotional states.
• Increase parent's ability to recognize ruptures in the relationship and facilitate repairs.
• Increase parent's capacity to provide comfort when their child is in distress.

COS educates, supports, and treats communication, stress, and emotional issues in families. The engagement process builds relationships. Case management and care coordination promotes successful outcomes for these parents and their children. This micro-innovation project will allow for the development of a trusting relationship to be built to engage an isolated and underserved population in their own language to improve bonding and attachment in their family.

2. How will your product/service promote this population of focus to seek mental health services when the need for mental health services has been identified?

Adapting COS and expanding access to Non-English-speaking individuals within the migrant farmworkers and Indigenous communities in Seaside and South County will promote fundamental improvements to the population of focus to seek mental health services. The relationship between child and caregiver has a significant impact on attachment and ongoing connection. Parents that have experienced complex trauma and live with mental health issues may struggle with attachment and emotional regulation. By supporting this group of parents in a way that helps them understand the role of attachment and how they can form positive relationships with their own children we can significantly build trust and confidence to improve both child and parent outcomes. DTH Care Coordinators will work diligently to build and gain the trust through meaningful conversations introducing Monterey County's mental health services to the migrant farmworkers and indigenous populations.

In order to succeed in connecting the migrant farmworkers and Indigenous communities with mental health services Comprehensive Case Management (CCM) must be provided. Case management is "a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive needs." DTH's case management is a coordinated approach to the delivery of health, behavioral health, and social services, linking clients and families with appropriate services to address specific discerned needs and promote

meeting identified goals and outcomes. This approach lends itself to gaining access to meet the needs of clients and families with multiple conditions and disorders who face difficulty in gaining access to services. COS will serve as the skill group and Comprehensive Case Management will engage, build trust, and help this community gain access to other mental health services in Monterey County.

3. How is this innovative? Please describe how your project is innovative. For purposes of this application, the term "innovative" includes, but is not limited to: the proposed work to engage the target populations has not been done in Monterey County before; the proposed project presents an entirely new practice or approach, or an adaptation of a successful practice or approach from a non-mental health setting, to improve access to mental health service; the proposed project is unique. Please provide supporting evidence to demonstrate the uniqueness of your proposed project, i.e. nothing like it currently exists in Monterey County.

This project is an adaption of successful evidence-based practices, i.e. Circle of Security and Comprehensive Case Management, with a new, un-studied, and difficult population. The integration of these practices delivers mental health services in an acceptable and allowable manner to a resistant group with language and cultural barriers. This is a unique opportunity that does not currently exist in Monterey County.

Communication and Engagement Strategy
1. How will you reach and interact with your identified population of focus to deliver the product/service(s) of your micro-innovation activity?

DTH has developed a collaborative relationship with aspects of this target population particularly through contracted services with South County schools, family resource centers, and other community providers and stakeholders. We provide parent education and play groups through contracts with First 5 Monterey County for families with young children ages 0 to 5 years old. We have excellent outreach and engagement strategies with the targeted population and community. We currently provide:
• Parent education services
• 15 playgroups each week in South County
• Serve over 100 families in target population
• Tri-lingual English, Spanish, and Triqui capacity.

DTH now wishes expand and enlarge our capacity within the migrant farmworkers and Indigenous communities to families with school aged and adolescent children at-risk for mental health problems. DTH has the bi-lingual and tri-lingual capability amongst culturally congruent selected staff members. These staff are already known and trusted in this community. DTH currently has the capability of providing COS in Salinas, Greenfield, King City and Seaside. In addition, DTH Care Coordinators can schedule home visitation, telephone and virtual platform appointments.

DTH's goals and objectives if awarded the micro-innovation grant are:
§ Expand its staff who are trained in COS and CCM to include those who speak Triqui,
§ Facilitate fidelity to the evidence-based practices,
§ Outreach to families with not only pre-school young children, but school-aged children and teenagers,
§ Provide COS skill groups,
§ Provide care management and coordination to increase accessibility for other appropriate mental health services in the family.

2. If your activity involves in-person contact, please describe how you will take precautions against the spread of COVID-19 and observe current Shelter-in-Place restrictions.

DTH is continuously monitoring and responding to the evolving situation around COVID-19, including taking special precautions to ensure the safety of clients and staff. Door to Hope has completed a detailed risk assessment, modified its facilities, and changed its practices to meet CDC guidelines and the current California Shelter-in-Place requirements for Monterey County. We have and will remain operational during this time with some modifications to the services we provide. Our staff has worked tirelessly connecting families to current virtual platforms and has had proven success. We are currently providing services to 170 families virtually in individual home sessions and play groups. We have completed 3 COS series, with 1 series of 8 in-person and 2 series of 8 virtually. We had great attendance in all that we offered. Due to current Shelter-in-Place restrictions COS will be offered on a virtual platform and as State and County guidelines allow, DTH will provide in-person sessions as well. We can offer in-person sessions in our accessible and convenient locations in Salinas, Greenfield, and King City.

Evaluation Plan
1. How will your micro-innovation activity provide individuals with information and referrals to obtain a clinical appointment? Who, as part of your project, will be responsible monitoring the number of referrals that are provided?

DTH Care Coordinators will provide participants of the COS sessions with information about mental health services. When needs for further mental health support are identified, our Care Coordinators will provide comprehensive case management services to assure families are connected and receive services. Each Care Coordinator will be responsible for monitoring the number of families served and the number of referrals provided.

2. How will you gather information from referred individuals to know if they were able to access/attend at least one appointment?

Each case that is referred to additional mental health services will be tracked until the outcome is reached. Care Coordinators will reach out to families routinely to gather information and provide support connecting with services if needed.

3. In addition to MCBH, will your micro-innovation provide referrals to other agencies for mental health services? If so, please specify.

Door To Hope has extensive experience and relationships with many of our county's mental health services. In addition to MCBH we can also refer families to our own ICT and MSTART programs as well as Harmony at Home, Community Human Services, PVPSA, Seneca Family of Agencies, Interim Inc., Sun Street Centers, Monterey County Probation Child Advocacy Program, Bienstar, and Centro Binational para el Desarrola Indigena.

How many individuals to you plan to serve or reach with your micro-innovation activity?
50 (enrolled into COS)

How many individuals do you plan to refer to mental health services?
25 (of COS participant to referred to MCBH/additional Mental Health services)

MILPA/Rancho Cielo Youth Leadership Training
Population of Focus
MILPA will focus on serving and engaging system impacted youth (particularly Latinx) who attend Rancho Cielo Youth Campus who are suffering from trauma, systemic racism, and chronic adversity and

historically have decreased access to mental health services. Rancho Cielo is a comprehensive learning and social services center for underserved youth in Monterey County and focuses on youth that have been impacted by the juvenile justice system and is currently or formerly on probation.

Problem to be addressed
System impacted youth in Monterey County are lacking access to appropriate social and emotional cultural mental health services. They are often exposed to community violence, lack positive adult role models and mentors, which in turn leave them prone to negative peer pressure, engaging in high-risk behavior. These services would address the chronic adversity, intergenerational trauma, and community violence caused by a host of racial inequities, white dominant paradigms, and systemic injustices that too often marginalize them based upon their race, class, and/or gender.

Proposed Micro-Innovation Activity
1. MILPA is proposing to provide culturally relevant mental health support and practices to system impacted youth under the Telpochcalli umbrella. Telpochcalli is a healthy and transformative space for youth. It was designed as a positive social outlet where youth can network with other youth while discussing topics related to racial inequity, civic responsibility and their overall well-being.

The Telpochcalli approach is a micro-innovation and supplementary practicum to the evidenced based curriculum of the Joven Noble and Xinachtli programs which often are implicit versus explicit when considering the impact of colonization, assimilation and acculturation related stress. However, due to the success and evidence of both the Joven Noble and Xinachtli we will be conducting them virtually at Rancho Cielo.

The core concepts and story science behind the Telpochcalli will increase the awareness, communication skills and provide them the ability to develop positive narratives about their community while exploring the social determinants of health. A critical element of Telpochcalli is to foster the critical consciousness learning around the racial inequities that are present in their day-to-day lives. Through this umbrella, youth are empowered to analyze the world around them, think critically about both problems and solutions, and create an action plan that fosters health for themselves, their families, and community. Joven Noble (Noble Youth) is a 10 week “rites of passage” curriculum which is culturally based and geared towards teen boys. Youth will develop leadership while addressing trauma, positive cultural identity, and how to develop strong self-esteem, in a safe and healthy mental space. Joven Noble is an evidence based program according to the Substance Abuse and Mental Health Services Administration (SAMHSA). Xinachtli is a12 week “rites of passage” curriculum which is a culturally competent bicultural youth character development process designed to provide teen girls the guidance and tools for self-confidence, resilience and leadership for a healthy development into adulthood.

2. In the structured virtual setting, Telpochalli will intake referrals, implement services, and refer participants to mental health services with MCBH. Telpochalli will bring forth an adaptation of a successful practice and approach from a non-traditional mental health setting, to improve and encourage access to mental health services. By fostering intergenerational mentorship with the staff of MILPA, youth will gain character development, social emotional wellness and mental health awareness. A highlight is that the youth themselves engage in a safe space and navigate peer to peer relationships in a prosocial way embraces the opportunity for self care and want to seek services.

3. The proposed MILPA innovation pulls from indigenious based practices, story-telling and from elders, who are often disregarded in our western modernized society. In addition, Telpochalli addresses the target population of Latinx communities as listed in MCBH Health and Equity report and applies a promising community-driven approach that has been successful in non-mental health context or setting

to the mental health system. MILPA is derived from the Uto-Aztecan Nahuatl word “Milli” that translates to mean "field" and is used as a proxy for the Tres Hermanas agricultural philosophy of planting beans, corn and squash and is reflective of village and relational values found in cultures throughout the world. As such the Tres Hermanas is an ancient tradition of working together in the community to achieve abundance, reciprocity, and sustainability. Applying cultural and inter-generational mental health services to our underrepresented and marginalized Latinx communities will create institutional change in mental health awareness. MILPA programming is innovative and holds promise to engage with these communities, examine how they are underrepresented, underfunded, and marginalized by institutions of power.

Communication and Engagement Strategy
1. In partnership with Rancho Cielo, MILPA will work with academic staff to identify populations of focus for MCBH that are currently enrolled in Rancho Cielo and that would benefit from MILPA services. We will use interactive and engagement software such as Zoom and Kahoot, to utilize technology and bring digital innovation. 2. Due to COVID-19, we plan to provide our services virtually, with the goal of working converting to in-person when Conditions change and we get guidance from health officials.

Evaluation Plan
1. We will work with MILPA’s and Rancho Cielo’s Therapist/Social Worker staff to develop and implement intake forms that will be collected from all youth participating in our programs. Demographics will be a part of the intake questionnaire along with asking if any participants have been referred to MCBH in the past. Program facilitators and internal data collectors will be monitoring all data and referrals. MILPA will also be collecting pre and post survey evaluations per program to review the impact on each participant.

2. If a participant is referred to MCBH, we will document the referral and send a copy to MCBH. We will also apply a follow up with that participant being referred to check on progress of receiving mental health and require to have their referral signed off by a MCBH official. Our goal would be to work with MCBH to ensure a harm handoff happens and the Individual receives the correct services. 3. MILPA strongly believes in the use of indigenous and culturally rooted practices that provide respite for healing and overall well-being. If any participant requests a referral to this approach, MILPA will refer participants as well to MCBH services as well indigenous elders.

How many individuals to you plan to serve or reach with your micro-innovation activity? 100

How many individuals do you plan to refer to mental health services? 20

Emeralda Owen/Public Service Announcements
Population of Focus
This is a MEDIA AND MARKETING INNOVATION IDEA to help disseminate information about mental health services in Monterey County to the Latino population. Most of the first and second generation Latinos who live in the County are of Mexican descent and speak Spanish. Some come from regions in Mexico that speak in dialects (Mixteco, Zapoteco, Triqui). This plan will cross over County lines into San Benito, Santa Cruz, and a bit of South Santa Clara Counties because of the nature in tools to be used to spread the information (TV/Radio/Social). For Monterey County, the focus will be the 101 HWY corridor which expands over 100 miles from Prunedale, Salinas, to South of King City. Other cities that will benefit are Seaside, Marina, Castroville, which house a great number of Latino families. I have a list of radio stations in our area who will (confirmed) provide free air time to talk about services in the area in short and long segments. I would consult with you first to make sure the correct information is

disseminated. In addition, a page on your website or phone number is recommended in order for the community to know where to start.

Problem to be addressed

In the Latin American culture, in general, mental health services are avoided at the fear of being labeled as insane, retarded or weak-minded. This is a stigma that stems from an early age where bullying among siblings, family members, or even classmates may play a role in how insecure individuals feel about this topic. The reason Latinos don't seek mental health services is mostly cultural, but these can be molded or adjusted with good information from trusted sources. Nowadays, more layers of trauma have been added to the already vulnerable communities. The Coronavirus, social and political unrest, etc. are creating even more anxiety in Latino youth and adults. A lot of Latinos in our communities face a lot of challenges each day, especially if they are undocumented or live in poverty or both. Gangs and drugs are infiltrating themselves into families creating destruction that cannot be repaired because help is avoided. Monterey County faces a lot of uncertainties for Latinos who deep inside, wish to do their best but are labeled even before they speak or do anything. This is not a good way to live. But even though Latinos are facing all these challenges, day in and day out, they are too proud to seek help.

Proposed Micro-Innovation Activity

My idea is to propose a MEDIA AND MARKETING INNOVATION PLAN. Being a journalist and an expert in marketing places me in a position of creativity and accessibility. I have contacts in the region that will provide me with air time to get the information broadly shared. With this plan, I will create 10-11 PSAs in Spanish for Television and Radio, plus translate them into the dialects mentioned for radio and social media dissemination. I plan to ask local Latino leaders in the community to be the face in some of the commercials to create relevance and familiarity. But I also feel it would be prudent to ask real members of the community struggling with any type of mental health issue. I will use my media expertise to place the PSAs in all Spanish speaking media in the Central Coast and seek opportunities with organizations that want to feature the PSAs on their websites or social media. If this proposal is accepted, the first month would be about the production of the 12-month plan, which would include the production of the first PSA. I will call in key individuals in the community and experts in mental health services to be a part of an advisory committee that will help me stay on track and to monitor, evaluate, and adjust the plan.

Along with the PSA and media outreach, I will design a pocket-size, quadfold document with resources for mental health services in the County. These will be delivered to homes with the use of volunteers and in targeted areas in South County, Salinas, and delivered to school parent coordinators, key programs and organizations in the community, etc. If the quadfold document idea is not suitable due to covid-19, I would love to offer a mini-conference to be delivered via Zoom and have experts in mental health present and answer questions. This can be something that can be offered at mid-point and make sure that the community is aware of it. I will make myself available and when possible have an expert with me for media interviews, shows, radio interviews, etc. In addition, I have found my press releases to be effective. The media loves information that is already written and I know exactly what they want and how they want it in order to be assured that the story or information will appear in the evening news that day.

Communication and Engagement Strategy

Most of the work will be crafted by me. As you can tell, I have already spent time designing the concept I am proposing. I would be able to execute the plan immediately upon approval. All the production of PSAs, marketing materials for social media, press releases, quadfold, etc. will be under my creative control. I will, however, need the help of a television production company for the creation of the PSAs, a graphic designer to create the quadfold (or magnet) and other relevant graphic designs, translators, do a call for volunteers, hire one or two interns. This is a project that will span through all 12 months and will

require constant follow up and follow through. I will develop a small advisory committee to help keep track of the project and provide extra resources or contacts I may need. Depending on how the advisory committee feels, we will meet monthly or bimonthly.

Evaluation Plan
The evaluation can take place on a monthly basis. I will use analytics, number of clicks on website, number of calls, number of likes on social media, and create a survey at midpoint and at the end of the campaign to evaluate and compare.

How many individuals to you plan to serve or reach with your micro-innovation activity? 40000

How many individuals do you plan to refer to mental health services? 5000

Round 5

Monterey County Public Health Bureau

Population of Focus

Monterey County Health Department's Chronic Disease and Injury Prevention Division currently serves Alisal and Everett Alvarez High Schools in the Salinas Union High School District (SUHSD) by providing training, education and resources in health education through Postpone (a teen pregnancy prevention program) to all incoming freshmen at Alisal High, and students taking health at Everett Alvarez High, by way of peer education and fotonovela (a storytelling tool to engage youth in learning about issues such as health and other adult preparation topics). Postpone has been implemented in our community for over 25 years.

While our current work provides youth with information and education related to their physical development, sexual and reproductive health, and other adult preparation areas, there is a gap. Our program does not currently address youth's mental health needs. Postpone facilitators agree that trauma, depression, and anxiety are among the mental health issues that are commonly observed in our program participants and are sometimes disclosed by the students themselves to our peer educators with whom they've built trust and rapport. These issues are often associated with adverse childhood experiences (ACEs), poverty, homelessness, violence, stress associated with being undocumented or being in a family with mixed documentation status, and family dynamics.

We propose to expand our work to address youth mental health needs by providing mental health education directly to youth and by making and tracking our referrals to Behavioral Health. Our project will focus on youth at the two high schools that we currently serve: Alisal and Everett Alvarez High Schools. According to Ed-data.org, during 2019 there were 2,988 students enrolled at Alisal High School and 2,306 students enrolled at Everett Alvarez. Our goal is to train a minimum total of 30 peer educators through implementation of the Mind Matters curriculum, a minimum of one public health student intern, and reach a total of 1,000 students from Everett Alvarez and Alisal through classroom presentations. We will train peer educators to complete one-on-one outreach to their peers, document their interactions, and post positive messages about accessing mental health services on their social media in an effort to reduce stigma and increase the understanding of mental health resources and services.

The schools' students are our proposed focus population and include a significant number of students who face language barriers in accessing County services. More than 25% of Monterey County's 434,000 residents do not speak English; approximately 100,000 speak only Spanish. In 2019-2020, approximately 88% of students at Alisal High School and 78% at Alvarez were a combination of English learners, foster

youth, or eligible for free/reduced-price meals. Both schools serve speakers of languages beyond Spanish, such as Tagalog, Korean, and many indigenous languages including Triqui, Mixtec, Zapotec, and Nahuatl.

In the city of Salinas, where both Alisal and Everett Alvarez High Schools are located, a Latinx family is three times more likely to live below the poverty level compared to a White, non-Hispanic family (2019 ACS, 1-Year Estimates US Census Bureau). The Centers for Disease Control and Prevention noted in a 2016 report (Vaughn, M.G., Salas-Wright, C.P. & Maynard, B.R. J Public Health (2014) 22: 265) that one important strategy to prevent and reduce health disparities is increased education in general, including high school completion. This proposal aligns with this strategy to support reducing health disparities and addresses some of the barriers to high school completion, such as teen pregnancy and unmet mental health needs. This project will also build on the success of the Postpone program in reaching and engaging youth to provide outreach, information, and referrals for youth.

Problem to be addressed

In addition to the language barriers described above, many of the youth that Postpone serves do not seek mental health services because they are often faced with immigration-related stress, reluctance to seek help due to stigma, lack of understanding by family and friends and/or not knowing where to turn for help. The peer education model is a health promotion method where students receive medically accurate information and resources from their peers. Often teens go to other teens to get help for things such as reproductive health, homework, where to find a job, etc. Having other teens come into their classroom to speak on topics such as depression, anxiety and mental health in general can help normalize mental health services and increase the likelihood that the youth in the classroom will seek help and not internalize stigma.

Prior to COVID-19, students were already struggling with mental health issues. According to Kidsdata.org in 2017-2019, in Monterey County, 28.6% of 9th graders stated they experienced feelings of depression. Why does this matter? Kidsdata.org states that mental disorders affect as many as one in five U.S. children each year and are some of the costliest conditions to treat—mental health problems among young people under age 24 cost the U.S. an estimated $247 billion annually. Unfortunately, many young people who need mental health treatment do not receive it, and mental health problems in childhood often have negative effects in adulthood.

By training the Postpone peer educators and at least one intern in the Mind Matters curriculum, at-risk youth will be given tools to seek help and address some of the mental health issues they might be experiencing. The peer educators will take what they learned from the Mind Matters curriculum and provide classroom outreach/presentations using the skills learned in Mind Matters. By having the peer educators present in the classroom and serve as liaisons of mental health, we will increase the number of young people who are likely to get these much-needed services in our community. Postpone peer educators will recruit students into mental health services provided by Monterey County Behavioral Health and other community partners such as Harmony at Home. The student intern will support referral follow ups.

Proposed Micro-Innovation Activity

To address the described barriers, the Postpone program will purchase from The Dibble Institute the evidence-based Mind Matters curriculum and training. Mind Matters is intended to help youth overcome adversity and build resilience. Mind Matters has been used to prevent violence, address chronic absenteeism, and build a culture of wellness. The Dibble Institute provides the following description of this course:

Mind Matters' practical, hands-on lessons explore the effects of adversity and toxic stress along with the healing process. Each lesson, based on ACEs science, includes activities on increasing hope, overcoming adversity, and building resilience.
The lessons address the following topics:

- Self-Soothing and Regulating Emotions: Cultivate a mindfulness practice
- Managing Stress Effectively: Learn to reduce intrusive thoughts
- Developing Empathy: Improve interpersonal communications
- Creating a Code of Honor: Develop a life of intention
- Building and Using a Support System: Learn how to ask for help

Postpone peer educators and a student intern, under the guidance of a public health coordinator, are a natural fit to learn this curriculum and apply the learned skills to their outreach and presentations. The skills taught in Mind Matters are designed to be practiced over a lifetime. The curriculum does not replace therapy. When the skills learned by peer educators are modeled to and shared with students, the curriculum will inspire, uplift, and build resilience of other youth.

Peer educators will present and promote program material to all the freshmen at Alisal High School during the Advancement Via Individual Determination (AVID) program. The AVID program is a nationally recognized program that prepares students, who are academically in the middle, for four-year college eligibility. Peer educators will also present at all health classes at Everett Alvarez High School. Educators will reach an unduplicated 1,000 youth through classroom presentations. This will be documented via sign-in sheets with student demographics. A post- evaluation survey will also be collected from each student and the knowledge attained will be documented onto an Excel form.

During the spring, a second training will be conducted for peer educators on the topics of the Mind Matters curriculum, sexually transmitted infections, human trafficking, and community resources. The presentations will be then conducted again in the AVID classroom, and health classes. The students who receive the fall presentation will receive a second presentation in the spring. The presentations will offer students an opportunity to ask questions and to be referred to the community resources that fit their needs. Just as in the fall, the spring presentations will be evaluated with sign-in sheets and a post survey with the new topics incorporated. As a result of our regular Postpone presentations, we see an increase in students accessing medical clinics for family planning, access, care and treatment (PACT). We anticipate the proposed and enhanced Postpone presentations with information on mental health needs and access will have the same results as we will be facilitating access to information and services.

The Mind Matters curriculum by the Dibble Institute will be implemented to all Postpone peer educators. Every effort will be made for educators to complete 100% of the training. However, if completion is not possible due to unplanned circumstances the educator must complete at least 75% of the training to continue as a peer educator. The information they learned will be shared with others via social media posts, and one-on-one conversations with students. These conversations will be documented on an outreach form and turned in monthly to the public health coordinator in return for a $20 gift card. The outreach forms will help us track the number of referrals and people contacted. Peer educators will also wear their Postpone T-shirts, a strategy we use to engage students. When wearing their Postpone T-shirts, educators will be regularly approached by students needing resources in the community. With support from Behavioral Health and the micro-innovation grant, we can create safer spaces for youth to receive information free of stigma.

Monterey County Public Health proposes an innovative project pairing our successful Postpone peer education program with an adaptation to include a focus on mental health services. Through Postpone, we will train and recruit high school students in Salinas, ages 13-18, to be part of the peer education

program. Peer educators will learn the standard Postpone topics in adult preparation, sexual and reproductive health, and with this grant will also learn to promote mental health and access to services. Peer educators will be trained to refer to Behavioral Health any youth who are in need of mental health services. For the past 25 years Postpone has given students the skills they need in adult preparation areas (e.g., advocating for themselves and others, learning public speaking skills) and becoming educated on important health topics. Peer educators have proven year after year that this model is effective in reaching other youth. Each year, Postpone meets or exceeds their reach goals of 1,000 students.

Postpone is open to all students enrolled at the targeted high schools, regardless of their grade point average and attendance. This ensures that Postpone is reaching youth from a variety of backgrounds and with varying needs. Postpone uses the Youth Development model: competence, confidence, connection, character, and caring/compassion. The Postpone program also functions as an official club at both schools and has a teacher as an advisor. The teacher/advisor serves as the liaison between the Monterey County Health Department and the school. Adding the Mind Matters curriculum, training our peer educators as facilitators in this new program area and teaching peer educators to identify the need for mental health services will be an adaptation from our current program. Postpone is a program of the Monterey County Health Department and as such there is not another program with this model in our County.

The schools will be open in the fall for student interaction; if another shelter in place order goes into effect, training and meetings will be held via Zoom. Classroom presentations can be scheduled via Google Meets at the high schools if necessary.

Although Postpone has been in existence for 25 years, its primary focus has always been on sex education. We plan to take this successful program, with our existing school and community contacts, and pivot the focus to mental health. In Monterey County we do not currently have a peer education program to promote mental health.

Communication and Engagement Strategy
The goal of Postpone is to improve the health of young people living in Salinas by focusing on health education, leadership, and advocacy. To accomplish this goal, the program works with community-based organizations, parents, teens, and schools. Public Health will reach and interact with our identified population of focus through Postpone.

We will train and recruit high school students in Salinas, ages 13-18, to be part of the peer education program. Peer educators will learn the standard Postpone topics in adult preparation, sexual and reproductive health, and with this grant they will also learn to promote mental health and access to services. Peer educators will be trained to refer to Behavioral Health youth in need of mental health services. Postpone provides students the skills they need in adult preparation areas such as advocating for themselves and others, learning public speaking skills, and becoming educated on important health topics.

At each one of the high schools we will train a minimum of 15 Postpone peer educators (a minimum of 30 total). Each peer educator will complete the Mind Matters curriculum from the Dibble Institute and will provide program information to fellow students via in person contacts and social media. Student interns in our teen pregnancy prevention program will also be trained in the Mind Matters curriculum and they will assist the Chronic Disease Prevention Coordinator with referral follow ups.

Recruitment of students for Postpone will occur at both schools. Each peer educator will fill out an application and a permission slip from their parent/guardian. The permission slips are important because students will be the liaison between County staff and other students on campus. The permission slips also serve to inform parents of the topics that will be covered. There will be two peer educator trainings at each school, one during the fall and one in the spring, for a total of 4 trainings.

The Mind Matters curriculum will not only assist our Postpone peer educators to clear away barriers to their own focus and learning but it will build skills in the peer educators that will transfer on through one on one interactions, presentations and other outreach strategies to the youth that they are working with. Peer educators will also learn to identify some of the signs which may indicate the need for mental health services such as declines in school performance, poor grades, constant anxiety, social withdrawal, or aggression.

Monterey County Health Department's priority is to always meet or exceed our annual reach goals. Prior to COVID-19, we had not experienced significant challenges in meeting our goals. However, the pandemic made it more difficult for us to reach youth. Our established relationship with schools and community members helped us to meet our reach numbers for fiscal years 2019/20, and 2020/21. Monterey County's shelter in place order has since been lifted. Should the County return to shelter in place restrictions, our program is prepared to return to offer activities through Zoom and other platforms as approved by the schools.

During the shelter in place orders, our program staff worked closely with teachers to record videos, pre-record sessions and to offer live implementation. The staff also trained on Microsoft Teams and Google Meets. Key to the success of our program is remaining in constant contact with school administrators. A close working relationship with administration at each site is required to build trust, schedule the program, meet student needs, and share community resources. Program staff meet with administrators to schedule implementation a few months in advance, and we discuss student expectations and site-specific programming.

For the upcoming school year school administrators have announced a requirement for students to come back to campus in person. Our program staff is prepared to serve students in person and/or virtually and will adhere to all State, County and school guidelines on social distancing and face covering requirements.

Evaluation Plan

Social media posts will be created to normalize mental health services, and peer educators will track the number of likes and reshares. Each student that attends the Postpone presentations will receive information about how to make clinical mental health appointments. When students ask for information from our peer educators, the educators will document the request on their contact sheet and ask permission for our intern to follow up with a referral to Behavioral Health (only phone numbers, age, and preferred name will be documented). If someone doesn't want to be contacted by our intern, we will ask the peer educators to follow up with them. Under the direction of the Health Program Coordinator, the program intern and/or Chronic Disease Prevention Coordinator will make weekly calls to new referrals to see if the students attended at least one of their BH appointments. We will also work with BH staff to create a referral code or other tracking method so that BH knows that students/ families referred came from our outreach efforts.

Under the direction of the Health Program Coordinator, the program intern and/or Chronic Disease Prevention Coordinator will make weekly calls to new referrals to see if the students attended at least one of their BH appointments, or if additional support is needed by the student to make a call or an

appointment. Logs/spreadsheets with non-identifying information will be maintained to track numbers and outcomes of referrals.

The Postpone program will add mental health services to their presentations, information will also be included on flyers and posted in the classrooms. Referral forms/discreet cards will be carried by all peer educators to refer students to services. Along with a contact log, educators will turn in referrals to the program coordinator or a program intern to forward to Behavioral Health. The program intern or program coordinator will follow up with referred students to ensure additional questions (if any) are answered or support is provided in making an appointment if needed. All students who are present during peer educator presentations will also receive a resource sheet of existing mental health services available in our county.

How many individuals to you plan to serve or reach with your micro-innovation activity? 1030

How many individuals do you plan to refer to mental health services? 103

Timeline
August 2021. Outreach to Peer Educators, recruit, distribute information, recruit minimum of 30 students, hire paid intern (if possible, Postpone alumna will be recruited for this position).

September 2021. Training #1 for peer educators, one at Alisal High, one at Everett Alvarez High, begin the Mind Matters curriculum, hold lunch meetings, begin to collect contact logs.

October/ November 2021. Begin Postpone presentations in classrooms, hold lunch meetings, collect contact logs, follow up on referrals.

December 2021. Hold lunch meetings, collect contact logs, follow up on referrals.

January 2022. Hold lunch meetings, collect contact logs, follow up on referrals.

February 2022. 2nd round of outreach for peer educators, distribute information, hold lunch meetings, collect contact logs, follow up on referrals.

March 2022. Training #2 for peer educators, one at Alisal, one at Everett Alvarez, finish Mind Matters curriculum, continue to hold lunch meetings, collect contact logs, follow up on referrals.

April 2022. Hold lunch meetings, collect contact logs, follow up on referrals.

May 2022. Hold lunch meetings, collect contact logs, follow up on referrals, school year ends.

June 2022. Presentations for summer school students, collect any remaining contact logs, follow up on referrals, prepare end of year report.

Total Budget Request 50000

Labor Costs 27183

<u>Please explain/describe your Labor Costs</u>
One student intern to work part time .5 FTE (approximately 48 weeks).

$18.39 x 20 hours x 48 weeks=$17,654
8% Benefit rate=$1,412
Total Benefits and Salary for Student intern=$19,066
Effort will be made to hire Postpone alumna.

Health Program Coordinator to oversee program and supervise staff .05% FTE, $5787
40.26% Benefit rate= $2,330
Total Benefits and Salary for HPC = $8,117

Chronic Disease Prevention Coordinator = in kind

Material Costs 7817

Please explain/describe your Material Costs

- Supplies for trainings (Mind Matters trainings for Peer Educators), handouts, office binders, copies, $1,000
- Projector for presentations $500
- T-shirts, $12each x 30 t-shirts=$360
- Breakfast and lunch for youth participating in full day trainings, snacks for youth while at trainings. $300 breakfast x 2 trainings=$600, lunch $450 x2 trainings= $900
- Mind Matters curriculum by Dibble Institute $325 x 2 facilitators=$650
- Workbooks for instructors and peer educators $15 each x 30 workbooks= $450
- Curriculum binders for training $6 x 30 binders =$180
- mileage to schools for program delivery $1677
- Incentives for training participants such as stickers, pens, pencils, reusable water bottles, and referral cards $1,500

Other Costs 15000

Please explain/describe your Other Costs
$8,000 in gift cards for peer educators. Logs are kept to record all gift cards.
30 Peer Educators, 1 gift card each for 12 months, $20 each gift card = $7200
30 Peer Educators, 1 gift card each, $20 gift card= $600,
Contest 1 $20 gift card for 10 months=$200

•We expect 30 Peer Educators, and each will complete a monthly contact sheet and social media post. They will turn in their log monthly and receive a $20 gift card once a month for 12 months. We will also incentivize them with a $20.00 gift card once they complete at least 75% of the Mind Matters curriculum. We will hold a contest for the best social media post related to mental health; the post with the most likes will be the winner. We will select one winner a month for ten months; winner will get a $20.00 Target Gift Card.

$2,000 - Stipend for two teachers at each site. $1,000 x 2= $2,000

A stipend will be issued to help with cost associated with meetings, teacher support for program activities and scheduling at schools.

$5,000 - Training

• Mind Matters training for staff on curriculum from Dibble Institute and/or other relevant mental health training, conferences = CDPC, Student Intern ($2,500 each)

Community Human Services

Population of Focus

Community Human Services will work with the Monterey County Office of Education's Migrant Education Program to reach over 11,000 Latino migrant children and their families throughout Monterey County, including the Salinas Valley and hard to reach areas of South County. Districts include:

- King City Union School District
- Chualar Union School District
- Gonzales Unified School District
- Alisal Union School District
- Greenfield Union School District
- North Monterey County Unified School District
- Salinas City Elementary School District
- Salinas Union High School District
- San Ardo Union School District
- San Lucas Union School District
- Santa Rita Union School District
- South Monterey Co. Joint Union High School District
- Soledad Unified School District

*30% of MEP students are part of indigenous groups including Mixtec, Zapotec, Triqui and Puretecha of Michoacan.

Problem to be addressed

Latino and migrant farmworkers are a vulnerable population that face multiple threats to their mental well-being. Stress, anxiety and depression are some of the many behavioral health issues migrant farmworkers face. One of the greatest barriers for migrant families in taking advantage of the mental health programs and services available to them, is access. These challenges can be transportation, lack of understanding and knowledge of services offered and a lack of culturally relevant materials. In a report released by the Monterey County Behavior Health Department, Migrant Families were identified as needing assistance in finding and accessing available resources, addressing language barriers, support navigating healthcare enrollment process and accessing referrals to services for basic needs including mental health treatment.

Funds from this grant will go towards creating culturally relevant and linguistically accurate mental health materials curated especially for underserved Latino families in the migrant community of Monterey County. The goal is to leverage the existing relationship between the Migrant Education Program and Community Human Services to engage Latino families by disseminating materials via the MEP.

Proposed Micro-Innovation Activity

Since 2016, Community Human Services has partnered with the Monterey County Office of Education Migrant Education Program (MEP) by providing mental health workshops, parent education classes and co-hosting the annual Migrant Families Resource Fair. It was through this existing relationship that the need for materials to address the mental health needs of Migrant Families was brought to CHS. The MEP fully supports CHS and is eager to connect Migrant Families with the materials to communicate strategies and information to help support them as they work through mental health issues. If funded, our Mental Health experts will work with the 13 Migrant District Leaders to co-create materials that are relevant to their needs.

CHS will use our existing relationship with the MEP to address challenges within the Hispanic/Latinx community and create access to information and materials to this otherwise hard to reach community. CHS will create quarterly (4) culturally relevant and linguistically accurate mental health education materials to engage the Latino Migrant Community and "meet them where they're at."

Communication and Engagement Strategy

CHS will create quarterly information packets addressing mental health issues and disorders migrant families face including but not limited to stress, anxiety and depression. These materials will include contact information for the Monterey County Department of Behavioral Health and Community Human Services to seek treatment if needed. The Migrant Education Program will then disseminate materials to families via direct mail, social media, at school sites and, through Migrant Family Advocates (MFA's), and during regional district meetings.

Evaluation Plan

The desired impact of this program is to provide targeted information and referrals to Monterey County Latino/migrant students and their families that lead to increased enrollment of Latinos/migrant individuals in mental health services. We will track the number of information packets distributed through the Migrant Education program. Demographic data in Avatar will show any increase in engagement of the target population.

Also, each of the thirteen migrant districts have MFA's assigned to students and families. MFA's provide recruitment, record keeping, and supplemental instructional services to students. MFA's will gather interested individual's contact information to relay to behavioral health to seek treatment. We are not sure how many referrals we will receive but our thinking is that the MFA's are trusted resources for many families and that they will be more willing to share contact information with MFA's than with other outreach specialists.

Success in this project will be measured in two ways. The first is simply providing information about mental health and mental health services to a population that traditionally has a low level of access to that information. We will know we are successful by providing information to 11,000 children and their families through a trusted source. The second measure of success will be signing individuals up to receive follow up contact from MCBH, ultimately resulting in enrollment in services. We will know we are successful by the number of referrals MFA's are able to collect.

How many individuals to you plan to serve or reach with your micro-innovation activity? 11000

How many individuals do you plan to refer to mental health services? 200

Timeline

The grant period will be October 1, 2021 – September 30, 2022. We will develop quarterly information packets on the following schedule. Supporting advertising will be scheduled these months, as well.

October 2021 – Suicide Awareness and Resources (October is the highest month for suicides.)

February 2022 – Relationship Building and Healthy Family Dynamics

May 2022 – Topic TBD between CHS and Migrant Education Leaders

September 2022 – Topic TBD between CHS and Migrant Education Leaders

Total Budget Request 24060.5

Labor Costs 4650

Please explain/describe your Labor Costs
Bilingual Communications Coordinator Salary: Hourly rate of $31.00 x 150 hours = $4,650. This will include time to create all materials and to distribute to the Migrant Education Program.

Material Costs 11000

Please explain/describe your Material Costs
Includes copier/paper expenses for material creation. 44,000 pages will be printed (4 printings x 5 pages each = 20 pages per student x 11,000 students = 220,000 printed pages. Cost of .05 cents per page.

Other Costs 8410.5

Please explain/describe your Other Costs
Mileage: $0.545 per mile x 50 miles x 10 trips to distribute materials and attend meetings with Migrant Education leaders (Average of 75 miles per trip/event) = $272.50.

Advertising: $5,000 for supporting advertising on El Tricolor Spanish radio and MST bus billboards. Advertising is optional but recommended.

Admin/indirect: $3,138 for administration (15%). Admin will be reduced if advertising option is not funded.

Awarded Project Descriptions Not Yet Started (Unedited)

Round 6

Door to Hope

Door to Hope (DTH) will collaborate with the Greenfield Union School District (GUSD) to conduct mental health, child development and behavior screenings to better serve an underserved community. The Micro-Innovations grant will allow DTH to connect services to underserved and unserved migrant farmworkers and the Indigenous population within GUSD. Over 2,000 vulnerable families have an established and trusted relationship with GUSD and DTH would like to utilize this connection by increasing the number of families connected to services available in Monterey County.

As of 2019, 40.7% of Greenfield residents were born outside of the country. Trauma endured before, during, and after migration, the struggles with behavioral and mental health concerns including post-traumatic stress disorder (PTSD), anxiety, stress, depression, substance abuse, and/or suicidal ideations pose an immediate threat to their mental health. It is important to consider the unique challenges and lifestyles of this population when it comes to their care, including how we address their mental health needs.

Population of Focus

91.1% of the residents in Greenfield are Hispanic/Latino, Spanish is the most common language spoken at home (47% of the households in Monterey County). However, many from indigenous communities speak neither English nor Spanish. GUSD estimates that 30% of their families speak a native language other than English or Spanish, Triqui is believed to be the language primarily spoken. At the Mary Chapa Academy in Greenfield it is estimated up to 60% of their families speak an indigenous language.

DTH has worked tirelessly to establish trusting relationships with the Indigenous communities within Monterey County. We have adapted to their needs by offering support in completing documents, providing parenting classes, child development education and mental health information and services in Spanish, Triqui, and English. DTH employs staff that speak the language, share in the same culture and live in the communities we serve. DTH staff understands the complex barriers preventing unserved and underserved communities from accessing metal health services. DTH can assist in meeting their needs in culturally sensitive and appropriate ways. The Micro-Innovations grant will allow DTH to assist in breaking the barriers and challenges non- English-speaking families in GUSD face accessing mental health services.

Problem to be Addressed

The Greenfield Union School District has approximately 3,500 students spread throughout 4 elementary schools and 1 middle school. Across the entire district there are only 2 mental health social workers assigned to provide mental health services for students and families. Each social worker carries a maximum caseload of 10 students at any given time. Currently only 20 GUSD students out of 3,500 are provided mental health services by GUSD. Limited access to developmental screenings, assessments, support, and case management is preventing students from accessing mental health services in Monterey County. Student access to comprehensive mental health services is essential to creating and sustaining safe schools.

Collaborative partnerships are crucial for an integrated system of care that includes education, mental, and physical health well-being. Mental illness or mental health awareness within the community is highly stigmatized and keeps families and individuals silent. Men, women and children are reluctant to speak about mental health issues they may be experiencing and often lack the education to even identity a mental health issue. The fear of emotional concerns being dismissed, the stigma around mental health, and the fears of mental health issues being discussed outside the home are a burden on families and individuals. The reluctance to reach out for mental health services is often out of fear of the unknown around what mental health is and what services could be like for a person.

Providing access to intervention services such as mental health screenings, education, case management, and referrals to services will build awareness, trust and confidence within the GUSD community. Creating culturally sensitive spaces will allow students and parents to begin exploring what mental health means to them. Mental health screenings and assessments will lead to referrals

in mental health services for more specialized support and care coordination. A tri-lingual Behavioral Health Specialist will reduce the disparities in order to build the relationships within the GUSD and will result in increased identification and mental health service delivery.

In collaboration with the Greenfield Union School District and the Salinas Valley Memorial Mobile Health Clinic, DTH will provide mental health screenings and referrals to mental health services for the students and families of GUSD. A Behavioral Health Specialist (BHS) native to the community's cultural practices and language, will provide screenings, mental health education, and case management for children 0 to 18 years of age and their parents. Culturally congruent and tri-lingual staff will collaborate with the district's community liaisons and school counselors to identify families with mental health concerns. GUSD will provide Door to Hope's Behavioral Health Specialists with an office to conduct the onsite screenings and education. In addition, once a week our Behavioral Health Specialist will have the opportunity to work side by side with the Mobile Health Clinic providing support for both the health and well-being of the community.

Screenings DTH will provide include:

- Ages and Stages Questionnaire (ASQ): A flexible, culturally sensitive system for screening infants and young children for developmental delays or concerns in the crucial first 5 years of life.

- Ages and Stages Questionnaire - Social Emotional (ASQ: SE-2): A parent-completed, highly reliable system focused solely on social-emotional development in young children. Accurately identifying behavior through ASQ:SE-2 paves the way for next steps—further assessment, specialized intervention or ongoing monitoring.

- Child Behavior Checklist (CBCL): The Child Behavior Checklist is a widely used caregiver report form identifying problem behavior in children and adolescents. The CBCL is a form administered by screeners with answers from parents or caregivers.

- Patient Health Questionnaire-9 (PHQ-9): The 9-question Patient Health Questionnaire is a diagnostic tool to screen adult patients in a variety of primary care settings for the presence and severity of depression. The PHQ-9 is a multipurpose instrument for screening, diagnosing, monitoring and measuring the severity of depression in adults and is administered by a screener.

The Behavioral Health Specialist will use mental health screenings as a tool to provide education around mental health for students and their families in their native language. The BHS will provide case management to students and families and will be available during open office hours to answer any questions or concerns families may have. If the need for specialized mental services and support is identified, students and families will be connected to services. DTH has the capacity to provide access to interpretation and transportation to mental health services in Monterey County assuring all barriers to accessing services are addressed.

Proposed Micro-Innovation Activity

Through our continued work within Monterey County, DTH has witnessed an increase in the success rate in specialized services accessed by underserved and unserved communities that is highly dependent on the support the family receives before and after the referral process. It is imperative that families referred to services understand why and how services will benefit their family. It is also crucial for the referring provider/case manager to remain connected to the family until the family

has established a strong connection to the new service as we know there are countless barriers that can come in the way of a successful connection.

Adapting mental health screenings and expanding access to Non-English-speaking individuals within the migrant farmworkers and Indigenous communities of the Greenfield Union School District helps students and families understand the importance of advocating for their own mental health and to trust in the delivery of health, behavioral health and social services that Monterey County has to offer. Building trust and confidence through mental health education and screenings improves student and parent outcomes creating a sustainable and safe space.

Students and parents that have experienced complex trauma and live with mental health issues may struggle with attachment and emotional regulation along with day to day functioning. DTH Behavioral Health Specialists will work diligently to build and gain the trust through meaningful conversations introducing Monterey County's mental health services to the migrant farmworkers and indigenous populations of GUSD. DTH Behavioral Health Specialists will be culturally responsive in their screenings and help educate this population on the importance of mental health services so there is an increased overall awareness to access services.

In order to succeed in connecting the migrant farmworkers and Indigenous communities with mental health services Comprehensive Case Management (CCM) must be provided. Case management is "a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive needs." DTH's case management is a coordinated approach to the delivery of health, behavioral health, and social services, linking clients and families with appropriate services to address specific discerned needs and to guide families in meeting identified goals and outcomes. By supporting these families in a way that helps them understand the importance of advocating for their mental health and not being deterred from seeking support we can significantly build trust and confidence to this population to improve student and parent outcomes.

A collaboration between the Greenfield Union School District and Door to Hope is unique, innovative and will promote fundamental improvements in seeking mental health services by students and families of the GUSD. Current mental health needs are not being sufficiently addressed or met by GUSD. Due to lack of resources and staff, mental health screenings, education, and case management services have not been developed between GUSD and other agencies. DTH would build on an existing relationship between GUSD and their families to provide the needed mental health education, screening and support. The integration of these practices delivers mental health information in a cultural and linguistically appropriate manner to a group with many language and cultural barriers.

The Greenfield Union School Districts Family Resource Center is a community hub that will provide an office for Door to Hope's Behavioral Health Specialist allowing for one on one interaction with families seeking resources and support. The Family Resource Center is a "One Stop Shop for Resources" with over 20 years of experience. The Family Resource Center is connected to all GUSD counselors, teachers, students and their families providing resources to Monterey County Services. Door to Hope will expand the Family Resource Centers capacity to families with children 0 to 18 years of age who are at risk for mental health problems.

Door to Hope currently provides:

- Parent education services

- Circle of Security
- 15 playgroups each week in South County
- Serve over 100 families in target population
- Tri-lingual English, Spanish, and Triqui capacity.

Communication and Engagement Strategy
Our staff is already known and trusted in this underserved community. We provide parent education and play groups through contracts with First 5 Monterey County for families with young children ages 0 to 5 years old. We have excellent outreach and engagement strategies with the targeted population and community.

DTH is continuously monitoring and responding to the evolving situation around COVID-19, including taking special precautions to ensure the safety of clients and staff. Door to Hope has completed a detailed risk assessment, modified its facilities, and changed its practices to meet CDC guidelines and the current California Shelter-in-Place requirements for Monterey County. We have and will remain operational during this time with some modifications to the services we provide. Our staff has worked tirelessly connecting families to current virtual platforms and has had proven success. We are currently providing services to families virtually and in-person individual home sessions and playgroups. We have great attendance in all that we offer. We can offer in-person sessions and virtual.

Evaluation Plan

DTH's Behavioral Health Specialist will provide students and families in the GUSD with mental health screenings, education and case management services using the industry-leading case management platform Apricot 360.

Apricot 360 combines case management with advanced data reports and analytics while connecting clients to services and providing comprehensive care. When needs for further mental health support are identified, our BHS will assure families are connected and receive services. Each BHS will be responsible for monitoring the number of families served and the number of referrals provided.

Greenfield Union School District Counselors and the Family Resource Center Community Liaisons will have the capability to refer appropriate cases to this Micro- Innovations grant program. Our Behavioral Health Specialists will review referrals and ensure both the student and family needs are met. Referrals will be tracked through our Apricot 360 database until the outcome is reached. The DTH Behavioral Health Specialist will reach out to families routinely to gather information and provide support. All services provided and outcomes will be documented in Apricot 360.

Door to Hope has extensive experience and relationships with many of our county's mental health services. In addition to MCBH we can also refer families to our own ICT and MCSTART programs as well as Harmony at Home, Community Human Services, PVPSA, Seneca Family of Agencies, Interim Inc., Sun Street Centers, Monterey County Probation Child Advocacy Program, Bienstar, and Centro Binational para el Desarrola Indigena.

How many individuals do you plan to serve or reach with your micro- innovation activity? 150

How many individuals do you plan to refer to mental health services? 50

United Way Monterey County

Population of Focus

The population focus for this work will be distressed Latinx youth in Salinas zip codes: 93905, 93912, 93915. Our intervention will target at risk youth who are experiencing mild to moderate mental health issues related to stress, anxiety, and depression.

The United Way Monterey County led a Countywide aspirations assessment in the summer of 2019. When we asked adult survey respondents to weigh in on their biggest health concerns, 57% told us that unmet mental health needs were a significant problem in their communities.

Among youth participants in 2019, top concerns consisted of diet, obesity and diabetes, unmet mental health needs, and drugs, smoking and alcohol abuse.

The 2020-2021 Monterey County Children's Council report documented that 19% of suicides were committed by children under 17, and 57% of attempted suicides were by children. The report also shows a significant increase in drug abuse and fatal overdoses for youth 15-24 during this time period. From March 2021 to March 2022, there were 1,764 calls for mental health supports to 211 in Monterey County. 55% of those calls came from Salinas.

The 2020-2021 Monterey County Children's Council report cites that the COVID-19 pandemic disrupted the lives of children and adolescents. Disruptions included in-person schooling, in-person social opportunities with peers and mentors, access to health care and social services, food, housing, and the health of their caregivers. The pandemic has exacerbated the overall mental health

challenges for children and youth as a result of isolation, fear, stress, and uncertainty. Their families also experience stress related to employment, wellness, and insecurity. Post pandemic, children in our community are facing trauma because of: child abuse; loss of a family member; decreased academic engagement/performance; extended period of social isolation; as well as everyday anxiety about the virus and unpredictable routines.

A report issued by the UC Davis Center for Reducing Latino Mental Health Disparities, cited, "five major themes related to individual-level barriers: (1) stigma associated with mental health problems, (2) cultural barriers, (3) masculinity, (4) violence and trauma, and (5) lack of knowledge and awareness about the mental health system."

Problem to be Addressed

The 2012 report issued by the UC Davis Center for Reducing Latino Mental Health Disparities, cited several themes related to individual-level barriers preventing access to mental health services. Negative perceptions about mental health care are perceived as a significant factor contributing to limited or no access to care. Among the many concerns, stigma, culture, masculinity, exposure to violence, and lack of information and awareness were the most common. These barriers persist today in Monterey County.

Latinos with limited English proficiency frequently do not have critically important information, such as how and where to seek mental health services. Moreover, language barriers contribute to the problems Latinos face when accessing public transportation to visit mental health clinics. Additionally, many Latinx residents are reluctant to provide required social security numbers and other personally identifiable information when completing mandatory paperwork at clinics.

A lack of sufficient bilingual and bicultural mental health professionals is another barrier. This usually translates into language barriers and often results in miscommunication and misinterpretations.

Focus group interview participants reported that limited or no access to mental health services was a significant factor affecting the mental health of the Latino community. There are limited social emotional and mental health programs and supports targeting Latinx youth. Those that exists are difficult to access.

In addition, the social determinants of mental health are barriers. These refer to the social conditions in which people grow, live, work, and age, and which have a powerful influence on people's health. In particular, social and economic resources and living conditions; inadequate transportation; and social exclusion can be factors restricting access to mental health services.

What product/service is your micro-innovation providing to this population of focus to address the barrier(s) described above?

The report issued by the UC Davis Center for Reducing Latino Mental Health Disparities indicated several core strategies to increase mental health supports to vulnerable Latinx residents:

Implement peer-to-peer strategies, such as peer support and mentoring programs, that focus on education and support services.

Create a meaningful educational campaign that is designed to reduce stigma and exclusion and that targets individuals, families, schools, communities, and organizations and agencies at the

local, regional, and statewide level

Building individual and family resilience (promoting connectedness, develop support networks, increased coping skills and parenting skills), building protective environments, strengthening economic supports for families, increasing awareness of mental health and suicide risk factors, and increasing access and delivery of mental health care

To address the barriers, youth experience in accessing mental health supports and implement recommended solutions, United Way Monterey County (UWMC) and its partners: The Boys and Girls Club on Monterey County; the Center for Community Advocacy (CCA), & Mujeres en Accion (MEA) will engage in the following activities in Salinas:

CCA & MEA Promotores de Salud serve as liaisons between mental health services and vulnerable Latinx youth and their families. Promotores will perform outreach activities, including sharing information on mental health issues and sending closed loop Smart Referrals to CCA and Boys and Girls Club youth programs that support: youth resilience, healthy lifestyles, compassion, self-efficacy, agency and leadership. In addition, BGC programs provide the following trauma-informed practices supporting emotional wellness:

- Provide opportunities to develop positive peer and staff relationships.
- Integrate opportunities for youth voice in activities, programs, and spaces.
- Create a safe and comforting physical environment.
- Adapt activities when needed to better support youth needs.
- Identify and refer youth to more specialized services when needed, ex: behavioral health agencies.

To build capacity, the Promotoes de Salud will receive training on common mental health issues Latinx children are experiencing as a result of the pandemic and adolescence. They will learn how to identify symptoms and provide psychological First Aid, tips, guidance, and community conversations (Platicas).

Promotores, youth, and families will also use the Smart Referral Network (SRN) bidirectional referral tool to make “closed loop” referrals to mental health support services. Service providers will monitor their SRN inboxes and document when referrals result in services.

Proposed Micro-Innovation Activity

The SRN is “smart” in that it compares client demographics with eligibility of services in the Monterey County 211 database to prioritize search results. Promotores will use the SRN to refer to additional Monterey County health and human services families may need.

To increase access and build capacity, UWMC will develop software on top of the SRN to allow families to “Smart Refer” themselves to the Boys and Girls Club program and other Monterey County health and human service programs. Prior to developing the software, we will conduct focus groups with youth and their families about how best to design and implement the software in a way that is effective and culturally appropriate.

How will your product/service promote this population offocus to seek mental health services when the need formental health services has been identified?

Trained Promotores de Salud will perform culturally competent outreach activities, including sharing informationon mental health issues and available services to vulnerable Latinx youth and their families in areas with historic lack of access to mental health services. Their interventions will target schools and housing developments that feed into Boys and Girls Clubs centers and programs. Promotores would provide mental health tips and guidance to those they identify as needing support. They will hold community conversations (Platicas) about common issues vulnerable Latinx youth are experiencing and attempt to reduce stigma and mental models related to negative perceptions of using mental health services. When they identify needed support, they would use the United Way Smart Referral Network (SRN) platform to do an intake, release of information, eligibility screening and electronic referral on behalf of a community member to a Boys and Girls Club program in Salinas. The parent or guardian would be referred as a proxy for their child. Additionally, UWMC will develop "chat bot" software to allow families to "smart refer" themselves to the Boys and Girls Club program and other Monterey County health and human service programs. The "Chat Bot" would live on public library and other community computers to allow parents to self-refer their children to the Boys and Girls Club program. Prior to developing the software, we will conduct focus groups with youth and their families about how best to design and implement the software.

The SRN is a HIPAA compliant program that protects client Protected Health Information and Personally Identifiable information. All Referrals and social determinants of health (SDOH) Reports made for clients with referrals to mental health programs are protected. Only users with granted access will be able to see protected information: Any information regarding the source of the referral. This includes:

- Program Name
- Agency From
- Referring User Contact Info

Any information regarding the outcome of the referral. This includes:

- Enrolled / Accepted / Declined

How is this innovative?
This approach is innovative for the following reasons: The Smart Referral Network (SRN) has not been used to facilitate access to mental health services. While many referral processes exist, none exist that allow for electronic sending of referrals and documenting when referrals result inservices. We will also develop a new feature that will allow parents themselves to send Smart Referrals for their children to participate in the Boys and Girls Club program. Our program approach will address the emotional and psychological stress parents and youth are experiencing by accessing youth to structured activities, mentoring programs, and youth leadership programs that:

- Match youth experiencing individual or environmental risk factors i.e. struggles with peer relationships and/or have been bullied, housing instability, or incarcerated parent to role models
- Provide robust learning, hands-on projects, guest speakers and field trips
- Provide a health, fitness, prevention/education, and self-esteem enhancement
- Addresses critical issues adolescents face including parenthood, decision-making and employment
- Where applicable work with an assigned mentor one-on-one for a minimum of one hour a week.

While program practitioners are not licensed clinicians, there is evidence that when youth are engaged in safe, predictable, structured activities with caring adults, they can reduce anxiety, depression, and mitigate post traumatic stress disorder. Parents' anxiety and stress are lessened by knowing their children are in developmentally appropriate and safe programs and have the ability to work and provide for their families.

Communication and Engagement Strategy
How will you reach and interact with your identified population of focus to deliver the

product/service(s) of your micro-innovation activity? Center for Community Advocacy and Mujeres en Accion Promotores de Salud are integrated in our targeted communities. They are respected leaders and have existing relationships with parents and youth. After receiving training, they will offer mental health tips and guidance to those they identify as needing support. They will hold community conversations (Platicas) about common issues vulnerable Latinx youth are experiencing and attempt to reduce stigma and mental models related to negative perceptions of using mental health services. They will make Smart Referrals to Boys and Girls Clubs programs and monitor referrals to ensure families receive services. These health care workers are essential to this intervention in that they live in the targeted communities. They are trusted voices that will communicate and engage about mental health in culturally competent ways. Boys and Girls Club will hold centralized orientation and registration events in a safe venue close to families. They will provide program information and answer parents questions. Where possible, Boys and Girls Club will offer transportation to programs for children that register for programs.

If your activity involves in-person contact, please describe how you will take precautions against the spread of COVID-19 and observe current Shelter-in-Place restrictions. Any program contact that involves in person contact will follow Monterey County and State of California public health guidelines for school, child care programs and community meetings. For example we would follow social distancing and face covering requirements when guided to do so by the Monterey County Health Department.

Evaluation Plan
How will your micro-innovation activity provide individuals with information and referrals to obtain a clinical appointment? Who, as part of your project, will be responsible monitoring the number of referrals that are provided? Promotores de Salud will serve as liaisons between mental health services and vulnerable Latinx youth and their families. Promotores will perform outreach activities, including sharing information on mental health issues and sending closed loop Smart Referrals to Boys and Girls Club social emotional support programs for youth. The Smart Referral Network (SRN) bidirectional referral tool allows users to make “closed loop” referrals to mental health support services. Service providers will monitor their SRN in boxes and document within the platform when referrals result in services. To increase access and build capacity, UWMC will develop software to allow families to Smart Refer their children to the Boys and Girls Club program and other Monterey County health and human service programs. Prior to developing the software, we will conduct focus groups with youth and their families about how best to design and implement the software. The United Way will monitor and report on referrals made in the SRN and that result in social emotional services in order to understand the effectiveness of the intervention. In addition, the Boys and Girls Club completes a weekly tracking sheet for children experiencing more moderate mental health issues. The tracking tool will document changes in targeted behaviors, program participation, other supportive activities or events, challenges, issues and concerns. Aggregated results data can be compiled to demonstrate overall improvements from children who participate in the program. Program challenges and lessons learned can be documented and reported. The Boys and Girls club will also provide aggregated data on those referred from the SRN. They will report on how many accessed services and how many continued to receive services.

Another component to this intervention will be pre and posttests administered during the community conversations.

These will be helpful in developing a baseline understanding of mental health mental models, knowledge, and barriers. This will be critical to tailoring future conversations andinterventions.2. How will you gather information from referred individuals to know if they were able to access/attend at least one appointment?

The Boys and Girls Club will receive an email notification when they receive a Smart Referral from a Promotores de Salud or parent. The email will inform them that a client has been referred and they should log in to the Smart Referral Network to access the parent's contact information. To ensure confidentiality, no information about the parent will be shared in the email. They will then reach out to the parent and attempt to enroll their child/children in their programs. When the child has attended at least one appointment, they will click "Enroll" in the SRN. This will indicate to UWMC staff with access credentials that the referred individuals benefited from services.3. In addition to MCBH, will your micro-innovation provide referrals to other agencies for mental health services? If so, please specify.

The Smart Referral Network (SRN) compares client demographics with eligibility of services in the Monterey County 211 health and human service database to prioritize search results. Over 40 community benefit organizations have signed an agreement with the United Way to respond to Smart Referrals and keep service information up to date. Available services include emergency food and shelter, childcare, support for individuals with disabilities, housing resources, financial literacy education and coaching, substance use disorders, domestic violence, and adult education. Many of these services provide mental health supports. Promotores will use the SRN to smart refer to additional Monterey County health and human services families may need.

How many individuals do you plan to serve or reach with your micro- innovation activity? 50
How many individuals do you plan to refer to mental health services? 75

Precious Stone PR Inc.

Thank you for the opportunity to submit this proposal to assist in disseminating important information about Mental Health to the Latino Community via a PSA Marketing Strategy. Public Information Announcements work well in our area because the media have to allot certain time to public services.

I am counting on my media partners to continue to support these efforts especially when these benefit Latinos and the LatinX community in a big way.

Population of Focus
In Monterey County, most of the first and second generation Latinos are of Mexican descent and speak Spanish. Some come from regions in Mexico that speak in dialects (Mixteco, Zapoteco, Triqui). This plan will cross over County lines into San Benito, Santa Cruz, and a bit of South Santa Clara Counties because of the nature in tools to be used to spread the information (TV/Radio). For Monterey County, the focus will be the 101 HWY corridor which expands over 100 miles from Prunedale, Salinas, to South of King City. Other cities that will benefit are Seaside, Marina, Castroville, which house a great number of Latino families.

In the last year, MCBH and its investment in PSAs in Spanish via an Innovation Grant, went a long way. The Spanish speaking population was actually calling the numbers seeking help! This is what we want them to continue doing.

With nicely edited storyboards on TV and Radio, and in their language, mental health is not as much a taboo as it used to be. With a new series of PSAs, I expect for that cultural avoidance of mental health services to lower. We need to let the Latinos that is okay to seek help. The PSAs help in putting families more at ease and willing to make that call for themselves of for their family.

Problem to be Addressed

In the Latin American culture, in general, mental health services are avoided at the fear of being

labeled as insane, retarded or weak-minded. The reason Latinos don't seek mental health services is mostly cultural, but these can be molded or adjusted with good information from trusted sources. Nowadays, more layers of trauma have been added to the already vulnerable communities. The Coronavirus, social and political unrest, etc. have created even more anxiety in Latino youth and adults. A lot of Latinos in our communities face a lot of challenges each day, especially if they are undocumented or live in poverty or both. Gangs and drugs are infiltrating themselves into families creating destruction that cannot be repaired because help is avoided. Monterey County faces a lot of uncertainties for Latinos who deep inside, wish to do their best but are labeled even before they speak or do anything. This is not a good way to live. But even though Latinos are facing all these challenges, day in and day out, they are too proud to seek help.

There is no better way to target thousands at a time than by using television, radio, and social media all together in an intentional and bold way.

Proposed Micro-Innovation Activity

I am excited to propose a 'Telenovela' style PSA project for this next round of Micro-Innovation grants. I will have one of these PSAs be in Triqui and one in Mixteco.

I have worked in Monterey County and in the Central Coast since 2005, first as a journalist and later as an expert in Marketing and Public Relations. I have also volunteered for non-profits, mentored youth and continue to do so, plus being key note speaker at various graduations and special events. What I have learned is that the need for Latinos to get help in mental health is huge. My friends from Partners from Peace (Vicki Law), Harmony At Home (Julianne Leavy), Girls Inc. (Patty Fernandez), Hartnell College (Jackie Cruz), plus others in the media and other organizations agree that services are underused and something needs to be done about it. These organizations know how much their clients need mental health services. They all love the idea of creating a marketing plan designed to cater to this population in particular.

Communication and Engagement Strategy
Being a journalist and an expert in marketing places me in a position of creativity and accessibility. I have contacts in the region that will continue to provide me with air time to get the information broadly shared.

I plan to ask local Latino leaders in the community to be the face in some of the commercials to create relevance and familiarity. I will use my media expertise to place the PSAs in all Spanish speaking media in the Central Coast and seek opportunities with organizations that want to feature the PSAs on their websites or social media (like Partners For Peace). If this proposal is accepted, the first month would be about the production of the 12-month plan, which would include the production of the first PSA. I will call in key individuals in the community and experts in mental health services to be a part of an advisory committee that will help me stay on track and to monitor, evaluate, and adjust the plan.

I will make myself available and when possible have an expert with me for media interviews, shows, radio interviews, etc. In addition, I have found my press releases to be effective. The media loves information that is already written and I know exactly what they want and how they want it in order to be assured that the story or information will appear in the evening news that day.

Evaluation Plan

The evaluation has come easy. More people calling the help lines, more clicks on the website, more people healing.

When you deal with Television and Radio, it is very difficult to tell how effective something you promote is.

But, the rule of these two is that if one person says that they heard or watched it on TV/Radio it counts for 1,000 people. I can evaluate this project by creating a simple survey to use right at the start of the project and then again at the end, BUT I believe that hearing from MCBH staff who respond to the help lines is a better testimonial of how much the calls have increased.

How many individuals to you plan to serve or reach with your micro- innovation activity? 60000
How many individuals do you plan to refer to mental health services? 10000

Denied Project Descriptions (Unedited)

Round 4

Jorge Rojas/ Monterey County Soccer Club
Population of Focus
Our population of focus will be individuals from Central America and Mexico, some with dialects from their region in which they came from. Our region will cover Monterey Peninsula, North County, Salinas and South County.

Problem to be addressed
The challenges facing this diverse population is that there are cultural barriers that we will be addressing to make the connection. For example, in South County the indigenous families from Oaxaca, one is to approach the male in the household before approaching the female which is a norm in that community. There are rules of engagement that we will be following to make sure we exercise cultural sensitivity. Having had multiple trainings in cultural sensitivity and other pertinent trainings, I feel that I can use that skill to train our team in being successful in making the correct connection with the families we intend to serve.

Proposed Micro-Innovation Activity
1) While many modern lists emphasize the minimum level of consumption of 'basic needs' such as food, water, clothing and shelter, our organization will also focus on sanitation, education, and healthcare. Once the basic needs are met, then seeking mental health services would be the next step in making sure the identified population gets the needing services. We would have a person on our team with training in mental health services and identification to help our team be better prepared. This person would also serve as the Facilitator once we start meeting with the families. We would provide wrap around services for the entire family.

2) Once the foundation is set in terms of the population to be served has the basic necessities, then "trust" would allow us the opportunity to refer our targeted population to seek mental health services. Having done work throughout the county, I have been able to make contact with all the diverse indigenous groups and have earned their trust.

3) This project is innovative as it would be the first time reaching this diverse population. Through our organization, Monterey County Soccer Club, which is the largest soccer organization in the tri-county and perhaps Northern California, we are able to connect with lots of members through the sport of soccer as most are current members in our organization and live throughout the county. Having over

6,000 members, and still growing, provides us the opportunity to reach out to the population we intend to serve.

Communication and Engagement Strategy
1) We will be reaching our identified population via soccer tournaments, sporting events and Soccer Finals to deliver our services. We will also announce scheduled events within different areas of the county to invite the community to attend and offer raffle prizes.

2) Our members of our organization will practice social distancing protocol. Our involved members will attend an orientation that will address the steps that we will be covering and breaking up the county into segments and make sure that we cover the identified population. Having participate in census counts, Housing Inventory Counts, Point in Time Counts throughout the county has allowed me to learn the skills to make sure that we cover all segments within our County.

Evaluation Plan
1) Our organization will establish and identify a Point of Contact within the Health Department to make the referrals and do a warm handoff once we start processing the referrals. Every team member in our organization will be responsible for tracking data and referrals provided. We will also do follow ups to make sure that the person who was referred, attended their session and received the necessary care that was needed.

2) We will create in intake system where we will be tracking our clients via excel to make sure no appointments were missed. If transportation is an issue, we will make sure to provide transportation to and from the site to make sure that no appointments are cancelled or missed.

3) Our organization will only provide referrals to MCBH and if the services are not adequate for the referred individual, then MCBH can make the decision to refer to another organization. We will make referrals to other non profit agencies in regards to other needs such as employment, housing, food, etc. Having worked with all non profit organizations in Monterey County, I have developed a good working relationship and have inside person from the organization based on the needs of the referred person.

How many individuals to you plan to serve or reach with your micro-innovation activity? 100
How many individuals do you plan to refer to mental health services? 40

Rocio Quintero/Gonzales Citywide Outreach
Population of Focus
Population of focus will be the Latino/a community of Gonzales who are in need of mental health support.

Problem to be addressed
Many within the Latino community go through mental health issues alone, whether that is because of stigma, not understanding that help is out there, or not knowing where to look for resources. Many suffer in silence and their suffering unfortunately contributes to a slew of other issues such as domestic violence, alcoholism, drug addictions, etc. The current COVID-19 pandemic has only exacerbated the issue and now unfortunately we have an alarming number of individuals feeling anxious, distraught and helpless. Entire family units are struggling and individuals of all ages, especially adults, don't know where to turn for help.

Proposed Micro-Innovation Activity

Though the activities proposed we will be providing a multitude of opportunities for community members to engage in mental health services. We know that one solution does not address the different problems that people are facing during this time and there is not a one size fits all way to engage everyone needing support. Therefore, our proposal offers a variety of opportunities by which individuals can first engage in services in a manner that makes them feel comfortable, safe and supported. By being able to provide a safe and encouraging environment for them through opportunities like painting classes, support groups and calming corners we will be able to begin engaging the public in an effort to share mental health resources and be able to connect them with the behavioral health system while assuring them that they are not alone. Additionally, our community health workers are trusted members of the public who are currently working on supporting COVID-19 relief efforts and who are encountering many individuals in need of mental health supports. Through their service they are working to build trust and relationships with the community and with this additional support they can make referrals and encourage the public to seek out much needed mental health services. Working collaboratively on this effort with help to streamline the way individuals from the City of Gonzales and its outskirts get connected to services.

Communication and Engagement Strategy
GUSD staff will utilize creative methods of engagement such as; Phone calls, snail mail, e-mail, flyers, text messages, voicemails, social media and canvassing. Additional engagement strategies include free food for participants, “goodie bag” filled with resources (mental health & covid) and access to mental health specialists. Community Health workers will collaborate with GUSD District Social Workers and will also provide referrals to MCBH upon encountering members of the public needing mental health support.

Evaluation Plan
At the end of every community mental health presentation we will provide the participants with a feedback survey in English/Spanish for presentation feedback and to evaluate the ongoing needs and address them. In addition we will provide a pre and post mental health test to determine if participants learned the skills and tools to address their own and families mental health needs. Data will be continually logged and tracked (demographics, engagement, attendance, referrals, referral outcomes) and all referrals submitted to MCBH will have case management follow up by GUSD staff to ensure linkage to services with MCBH.

How many individuals to you plan to serve or reach with your micro-innovation activity? 1000
How many individuals do you plan to refer to mental health services? 250

Emeralda Owen/Precious Stone PR
Population of Focus
This is a DIGITAL MARKETING idea to help disseminate information about mental health services in Monterey County to the Latino population. I have found this to be the best way to reach those we want to reach in a targeted and intentional way. Most of the first and second generation Latinos who live in the County are of Mexican descent and speak Spanish. Some come from regions in Mexico that speak in dialects (Mixteco, Zapoteco, Triqui). This plan will cross over County lines into San Benito, Santa Cruz, and a bit of South Santa Clara Counties because of the nature in tools to be used to spread the information (TV/Radio/Social Media). For Monterey County, the focus will be the 101 HWY corridor which expands over 100 miles from Prunedale, Salinas, to South of King City. Other cities that will benefit are Seaside, Marina, Castroville, which house a great number of Latino families.

Problem to be addressed

In the Latin American culture, in general, mental health services are avoided at the fear of being labeled as insane, retarded or weak-minded. It is taboo. The reason Latinos don't seek mental health services is mostly cultural, but these can be molded or adjusted with good information from trusted sources. Nowadays, more layers of trauma have been added to the already vulnerable communities. The Coronavirus, social and political unrest, etc. are creating even more anxiety in Latino youth and adults. A lot of Latinos in our communities face a lot of challenges each day, especially if they are undocumented or live in poverty or both. Gangs and drugs are infiltrating themselves into families creating destruction that cannot be repaired because help is avoided. Monterey County faces a lot of uncertainties for Latinos who deep inside, wish to do their best but are labeled even before they speak or do anything. This is not a good way to live. But even though Latinos are facing all these challenges, day in and day out, they are too proud to seek help. But if they hear it from a trusted source or see it in their language, they will more likely seek assistance.

Proposed Micro-Innovation Activity
No matter how rich or poor you are, reality is, you have a cell phone. This is why a Digital Marketing Campaign can be really effective in sending messages to whoever we want and as many times as we tailor it to be delivered. The power of technology allows us to now select regions, areas, people of certain ages, of certain styles, of certain anything to get the message you need delivered. With this campaign, I will create graphic designs to disseminate broadly. I would also utilize already produced PSAs (or produce new ones) to pop up for some of the clients. In addition, graphic designs will also be spread via social media by feeding them to community partners so they can post them on their timeline. For Latinos, sharing stories of other Latinos that are dealing with mental health issues and how they are overcoming them builds trust; for they to know that services are available in their language, free or not, and provided regardless of their legal status is key. In addition, pointing out what mental health issues look like and creating messaging that allows for acceptance. With the Digital Campaign and any campaign, some messages will be tailored as informative, some will be designed to take action. For the latter, I recommend having a phone number or a page on your Website that is designed specifically for this campaign. This will also help to track the progress of the campaign and serve as an easy way to get referrals or get paired up with the right program.

Communication and Engagement Strategy
I will create the timeline for this project and design the digital marketing concept, month to month. I will work with the local digital marketing expert to upload the concept and track how it is doing. With digital marketing, it is easy to get day to day reports on how many people are reached. They have the tools to give us weekly, monthly, and annual data to evaluate. A graphic designer will need to help me create the ads for dissemination. And PSAs that already exist or are being created by another consultant (or me) will be used on a monthly basis. An intern will be hired to help get all messaging on social media platforms with consistency.

Evaluation Plan
The evaluation can take place on a monthly basis. I will use analytics, number of clicks on website, number of calls, number of likes on social media.

How many individuals to you plan to serve or reach with your micro-innovation activity?
25000

How many individuals do you plan to refer to mental health services? 5000

Timeline

This plan is for one year. The information to be disseminated will be designed in a timeline. Each month we will focus on different programs, graphics, themes.

Total Budget Request
50000

Labor Costs
20000

Please explain/describe your Labor Costs
Project manager wages for the year. Intern stipend.

Material Costs
28000

Please explain/describe your Material Costs
Costs of digital marketing services for one year. Graphic designs.

Other Costs
2000

Please explain/describe your Other Costs
There will be costs of mileage, cell usage, meetings (meals), liability insurance for contractors, any other media tool needed, plus any other overages.

Round 5

CSUMB MSPA
Population of Focus
Migrant farmworkers in Monterey County and South County.

Problem to be addressed
Patient are not given tools to address daily stressors of life. There is a time lag to get in to see a mental health provider. We plan to close the gap by offering tools that patients can practice at home to improve their mental health.

Proposed Micro-Innovation Activity
We plan to offer a curriculum of mindfulness, meditation, decentering to these at risks groups by creating focus groups and having our faculty and PA students lead the trainings.
This gives our students exposure to this at risk population utilizing the curriculum they have learned during their tenure at the PA program. All of our students are fluent in Spanish.
This will give our population tools to cope with until they get to see their provider.
The proposed project has not been done in Monterey county.
It is innovative in that we are meeting our program's mission of serving the undeserved and we are able to fill the gap of the lag time from onset of mental health systems to appointment time. While having these tools, the patients will be referred to their providers and be given a strategy to cope at home.

Communication and Engagement Strategy

We plan to advertise at local farmworker health clinics in our area since we have many connections with mental health providers that our student do their internships at. We also have a strong relationship with Monterey County behavioral medicine.
We will create times where we can meet with the groups of patients and offer mindfulness curriculum.
All of our students/faculty/staff are doubly vaccinated against Covid and are required to wear PPE.

Evaluation Plan
We will appoint a lead to monitor the number of referrals provided.
We plan to partner with the local health clinics to get access to their pamphlets for mental health referrals and Monterey County behavioral medicine.
We would work with the clinic they were referred to monitor the number of appointments.

How many individuals to you plan to serve or reach with your micro-innovation activity? 100

How many individuals do you plan to refer to mental health services? 100

Timeline 12 months

Total Budget Request 1000

Labor Costs
100

AIM Youth Mental Health

Population of Focus
The focus population this program will serve is Monterey County teens (ages 14 - 18), their parents, and high school educators and counselors, with an emphasis to serve ESL / Spanish native Hispanic / Latino youth in the Salinas Valley, North county, and South county regions. A large percentage of these students are among a lower socioeconomic status (LSES) who've been most affected in mental and physical distress due to the COVID-19 pandemic; especially those living at or below the poverty level with high density home conditions. In Monterey County, Latinos and Hispanics make up over 60 percent of the population, but over 84 percent of hospitalizations and over 75 percent of COVID-19 deaths. Pre-pandemic, these groups already experienced higher rates of need as mental health and addiction conditions are often activated or exacerbated by social determinants of health such as poverty. In the US, children under 18 years old are disproportionately affected by poverty, making up 33% of all people in poverty. Living in a poor or LSES household has been linked to poor health and increased risk for mental health problems in both children and adults that can persist across the life span.
Despite the mental health needs of Monterey County families living in poverty, few have sought access to participate in mental health services activities. There is a growing urgency and ripe opportunity to develop integrated models of mental health care that are tailored to the needs of these vulnerable children and their families.

Problem to be addressed
Monterey County teens, particularly in Hispanic/ Latino communities living in poverty, face a range of barriers that reduce their interest and/ or ability to access mental health services, maintain compliance with treatment, and achieve favorable treatment outcomes.
Our local teens and their parents experiencing poverty encounter social and psychological barriers:
The stigma of mental health treatment

The stigma of living in poverty may generate self-blame and self-loathing, which may inhibit seeking care.

- Parents raising children in poverty, particularly mothers, may fear being labeled “crazy,” concerned that a diagnosis may cause their children to be removed from their care.
- Mistrust of the mental health care system, perceiving that any disclosure of mental health problems may result in hospitalization, overmedication, or separation from children and family.
- Misaligned messaging and/ or gaps in cultural competency among mental health resources and stakeholders

Instead of seeking treatment, these teens and their families may rely on their own limited coping skills, support from peers, or ignore the mental distress altogether. Even when treatment is being sought, socioeconomically disadvantaged teens and families face greater difficulty with treatment engagement and, even when they complete treatment, may not benefit to the same extent as higher-income families.

Consequently, there is a need for more upstream, innovative, comprehensive approaches to address mental health problems among teens and their families experiencing poverty in Monterey County. Specifically, innovative programs that have families engaged, teens in their natural contexts, incorporate evidence-based interventions (emphasizing research findings), and take a comprehensive culturally-competent approach to treatment that addresses relevant social determinants (eg, housing or food insecurity) may be associated with greater therapeutic assessment, diagnosis, and increased completion of treatment.

Proposed Micro-Innovation Activity

There is a growing consensus among specialists in pediatrics, psychiatry, psychology, and child advocacy that integrating mental health services into existing services settings, including pediatric primary care and educational institutions, is the most promising means of increasing access to mental health care, particularly for children from low-income families.

Simultaneously trending, school districts across the country are developing a new kind of partnership with researchers in long-term collaborations that are organized to investigate problems of practice and generate solutions for improving outcomes. This is particularly useful in schools supporting the roll out of new mental health initiatives. In the context of a mental health prevention, intervention, and education, strategic research-practice partnerships can foster reciprocal learning and develop effective mechanisms for broad communication and co-management of mental health referral needs between providers including clinical researchers, primary care clinicians, mental health professionals, school personnel, and case managers.

Innovative youth mental health approaches must go beyond overcoming stigma campaigns, and commit to initiatives which regeneratively elevate youth voices in mental health research and clinical practice priorities. New and creative ways to engage teens in discussion with peers and mental health experts, while directing insights and assessed needs to clinical research and mental healthcare practice is essential to address youth mental health issues.

In response to both the need and opportunity, AIM Youth Mental Health, a 501c3 nonprofit based in Carmel, will be launching the AIM Ideas Lab, a unique youth participatory action research (YPAR) pilot program to extend mental health education, prevention, and intervention with high school students, educators, youth counselors, parents, and youth serving organizations in Monterey County, CA.

The purpose of the Lab is to:
- Engage youth in the mental health conversation,
- Raise awareness of the need for the science/research to find solutions,
- Build advocacy for mental wellness,
- Include youth with lived experiences in the research strategic decisions,
- Educate youth on evidence-based solutions and,
- Cultivate awareness and trust in the efficacy of evidence-based treatments and delivery systems.

The AIM Ideas Lab models a research practice partnership to address the pressing need for mental health intervention and education among teenage youth at risk for depression, anxiety, and suicidal thinking, while directing lived experience in mental health concerns to the attention of researchers dedicated to overcoming these challenges. The AIM Ideas Lab will curate scientific inquiry among teens, in collaborative response to published scientific research and researcher-led discussion of youth mental health topics. There will be an emphasis to present on youth mental health studies with trial participants that reflect the demographic of the Ideas Lab cohorts.
Participating students (ages 14-18) will collaborate in a small group setting to:

- ignite student advocacy for mental health solutions; exploring evidenced based youth mental health research,
- ideate on the most pressing mental health issues and formulate questions they would like researchers to answer,
- elevate youth voices in mental health research priorities.

<u>Deliverables / Executable Service</u>
The Ideas Lab will catalyze entrepreneurial thinking amongst students, serving up to 250 Monterey County High School students within a 10 hour program hosted over 8 weeks.
Program recruitment begins in the Fall 2021 with Lab cohorts hosted in the Spring 2022.
Student participants will include those in underserved communities hardest hit by the COVID pandemic, having an increased need to access mental health support services.
Delivery of curriculum may be in person or virtually. All program material will be accessible online. Depending on funding, participants may have the opportunity to leverage sponsored access to web and mobile applications and devices to support their mental wellness practice. Parents and teachers of participants will receive access to mental health first aid training as an intervention component to support the teen participant on-going.
<u>Ideas Lab Curriculum Outline</u>
Week 1: Course Overview & Introduction
Week 2: Researcher, Local Mental Health Specialist, & Mental Health Resources Presentations/Panel
Week 3: Researcher, Local Mental Health Specialist, & Mental Health Resources Presentations/Panel
Week 4: Researcher, Local Mental Health Specialist, & Mental Health Resources Presentations/Panel
Week 5: Introduction to Participatory Action Research & Student Projects
Week 6: Student PAR project development
Week 7: Student PAR project development
Week 8: Student PAR project development
Week 9: Student PAR project presentations
Week 10: Student PAR project presentations

The AIM Ideas Lab will maximize outcomes to uniquely build capacity and generate collaborative discussions with numerous Monterey-based healthcare specialists and mentors from youth serving organizations supporting the AIM Ideas Lab. This includes development of new channels for MCBH to

influence and increase mental health referrals in Monterey County among Spanish/ Latino community members.

Capacity Building with Mentorship

Students and participating teachers will be aligned with trained Ideas Lab program mentors from:

- California State University Monterey Bay
- Monterey Peninsula College
- Hartnell College
- Salinas Valley Adult Education Consortium
- Monterey Cadre Leadership Program
- CHOMP
- Montage-Ohana Mental Health
- Harmony at Home
- Community Partnership for Youth
- City Youth Councils

AIM will leverage its world-renowned Scientific Advisory Board (SAB), funded researchers, and network of mentoring partners to lead in safe, trauma-informed think tank sessions within teen cohorts. The AIM SAB will review the student submissions for questions needing scientific investigation and provide feedback/ constructive coaching to Lab participants. Insights gained in the AIM Ideas Lab will be made available for educators engaged in the program as well as MCBH stakeholders.

As one of only four U.S. based members of the International Alliance for Mental Health Research Funders (IAMHRF) focusing on youth mental health research, AIM will also share Lab insights with the Alliance to build upon their commitment to increase inclusion of youth engagement in mental health research at a national and global level.

Implementation

Mental Health Connect (MHC), a mental health education consulting firm, will design the program, deploy the pilot, and monitor student impact. AIM will fund the project (along with community supporters), promote the program, and aid MHC to align subject matter expertise (i.e. clinical researchers and mental health professionals) to deliver the educational aspect of the Ideas Lab sessions.

We propose the AIM Ideas Lab will:

● Transform students' understanding of the relationship between scientific research, treatment for mental health disorders, and practices of mental wellness in all youth participants

● Empower High school students suffering from post-traumatic stress disorder (due to pandemic) and/ or related symptoms to have access to scientific experts, well-trained specialists in the community, and self service resources.

● Increase the desire to seek treatment as a result of decreased levels of stigmatization and discrimination, encouraged by youth program participants.

● Monterey County mental health specialists (counselors and therapists) as well as non-specialists (educators and college level mentors) have access to adequate capacity development opportunities that enable them to provide high-impact student engagement.

● Build youth mental health research priorities pipeline

● Pilot model to scale on-going PAR / Research Practice Partnership

The AIM Ideas Lab is a new, unique pilot program to Monterey County, as there's no similar program addressing youth mental health using the proposed YPAR and researcher-practice partnership approach.

AIM is aware of one established collaborative research-practice partnership among Alisal High School students of Monterey County and UCSC researchers from the Genomics Institute of Office Diversity in Santa Cruz County, however, this program focuses on STEM education, with zero mental health components.

Communication and Engagement Strategy
AIM has partnered with Mental Health Connect (MHC), a Monterey County based consulting and teaching organization specializing in inclusive mental health education.
MHC will support program design, recruitment, delivery of all Ideas Lab cohort sessions, and program evaluation.
The Ideas Lab will be hosted via virtual meetings using video conferencing and online collaboration tools.
All content will be available online.
The Ideas Lab will engage with up to 250 Monterey County High School students within a 10 hour program hosted over 8 weeks.

AIM Youth Mental Health has already received Ideas Lab participant interest.
Program recruitment begins in the Fall 2021 with Lab cohorts hosted in the Spring 2022.
We will leverage our community partners, including Monterey County's School District Superintendent and High School Principals to promote the pilot program for participant registration.
About Mental Health Connect
MHC is dedicated to guiding the shift in schools and non-clinical organizations with integrating and providing inclusive youth mental health environments.

Evaluation Plan
As part of the program assessment, Ideas Lab participants will provide their feedback at the start and finish of the program. This assessment will inquire on the likelihood of that individual to seek and receive mental health treatment if needed, and identify if a shift in this likelihood took place during the Ideas Lab. Other measurable insights from Lab participants, pertaining to attitude and trust in accessing mental health care and direct feedback into the teen population's belief in what's needed to overcome barriers and challenges in mental health care access, can be provided for MCBH and other Monterey County mental health stakeholders.

Measuring Success Outcomes
The following measurements will be captured via Lab participant assessment and overall program activities:
Population Health Assessment
- Stress level
- Mental health
- Physical Health symptoms

Engagement in Program
- Attitudes and understanding of mental health and research
- Lived experiences in mental health disorder

Youth Initiated Research Proposals
- Pipeline of qualified research questions

The Ideas Lab will host a training on mental health first aid from the National Council for Mental Wellbeing to serve as a skills based course for parents and school educators of Lab participants, in helping to develop an inclusive support system to address mental health and substance use matters. The participation in mental health has the potential to influence trust in the outcomes of seeking mental healthcare. It is also possible to promote paths to seek treatment as proposed by MCBH.

How many individuals to you plan to serve or reach with your micro-innovation activity? 300

How many individuals do you plan to refer to mental health services? 50

Timeline
The AIM Ideas Lab timeline:
- August 2021 through October 2021 - Curriculum design
- October 2021 through February 2022 - Program recruitment
- March 2022 - May 2022 - Ideas Lab cohort sessions are live
- June 2022 - July 2022 - Evaluating and sharing of YPAR insights with community stakeholders

Round 6

Majesh Natrajan

Our innovation project "Heal" introduces holistic, mindfulness-based sound meditation treatment practice in Monterey County aimed at relieving symptoms of mental health issues. We do this with an immersive on-demand multi-sensory meditation pod like structure, called "Heal"

Heal uses sound therapy as the “training wheels” as foundation for a strong long term meditation practice that enables participants to be mindfully engaged. The intervention is aimed at relieving stress, depression, feelings of detachment, coping skills, irritability, anxiety and physical pain, and can be integrated into Monterey County’s prevention and intervention programs to address and/or supplement treatments for a range of mental health symptoms and concerns Heal can also aid in relapse prevention, recidivism prevention and help with reentry.

Additionally, this can help the community with early prevention of onset mental health concerns. Heal is an effective, adoptable, and sustainable treatment that can help reverse the growing upward trend of mental illness in Monterey county over time.

In terms of form factor, Heal is a physical sound space with a footprint of roughly 3 feet by 3 feet that takes about 2 hours to fully install. The participant sits on a (cushioned) bench inside the "Heal Pod", which plays short 3-20 min audio pre-recorded orchestrated sequence of therapeutic sounds. These sound meditation sessions are designed to boost immune levels & functions (Trends in Cognitive Sciences April 2013, Vol. 17, No. 4 pg. 187, 188), help in coping with stress, depression, feelings of detachment, irritability, anxiety, and physical pain. It is highly recommended that participants are consistent with the use the Heal Pod 2-3 times a week with each session lasting 12-20 minutes and leaving 10-15 mins post-meditation to document and journal in the questionnaire form provided for a minimum total time period of at least 6 weeks. The weekly frequency and per session duration can be increased and the specific meditation tracks recommended over time in consultation with participants’ therapist. As the participants get deeper in their practice, the duration of each session

can also be increased from 12- 20 minutes to one-hour meditation sessions.

Heal is designed to maximize the experience of being part of this testing method and intervention as opposed to 'learning' any other form of mindful meditation in that the results provided indicate a level of stress reduction that does not require the individual to learn a disciplined form of meditation. There is a passiveness approach to this engagement that reduces barriers to first-time and skeptical participants.

These sounds envelope the patient in 360 degrees soothing surround healing music, getting them to a stress free, happy and comfortable state of mind almost immediately; much like the vibrational happiness infants experience inside the womb of their mother, or while listening to classical music.

The benefits of Heal sound meditation session extends beyond the time they spend inside the Heal pod to help them continue with their day being a little calmer, collected, and better prepared to cope with stressful situations.

The Heal experience is designed to be used with a curriculum that has been created and curated with clinical psychologists and therapists in the medical field and recovery centers. The therapists will work with participants and use journals, questionnaires and group discussion to assess the participants engagement and results from each of the Heal session.

The curriculum, much like a classroom curriculum with measured outcomes, for the Heal includes:

- Verbal intake & introduction to the concepts of the Heal and sound meditation. (There is an introduction 15min meditation track that walks the patient through what to expect, do's and don'ts, and how to get the most out of each session)
- One-time scheduling of 3 sessions a week for 3-20 mins each Short 5-7 min self-evaluation after each session.
- Weekly/monthly review of the wellness forms to track progress on how this has affected their life's daily outcome with a counselor
- "End of program" evaluation with counselor (exit interview).

The purpose of the curriculum is to enable both the participants and the county to track and assess the participant's responses to treatment made week over week. This way any expected outcomes established at the beginning can be evaluated at exit from the jail system.

This curriculum is template driven that can be easily customized to a given participant given their needs for the treatment plan and specific disorder being treated.

Appendix D: Project Evaluation Reports

Round 4

Michael Houston/Greenfield Cultural Arts Events Outreach

Final Report
Mi Vida, Mi Arte, Mi Alegria South County - June 2021 - June 2022

MIG2- Houston Background & Purpose

Mi Via, Mi Arte, Mi Alegria South County (MIG Houston 2) was designed to address the Monterey County Health Department's Behavioral Health Branch gap in services provided to Latino populations by using community artist performers to share experiences to counter attitudes of the stigma associated with mental health issues with recognized community artists promoting access to mental health services in a safe family-appropriate environment. Surveys track community attitudes and provide the County with data to improve its outcomes. Project leads receive an orientation and experience from the project to go forward with sufficient knowledge and means to provide referrals to community services including school counselors, Interim Inc housing, Sun Street intervention, Partners for Peace parenting, Catholic Charities service, and online support groups, and Blue Zone lifestyle workshops.

The program's outreach used face-to-face contact with collaborating organizations' digital media to promote the events. AMP Media and Alegria Musical en Radio y TV will broadcast and produce videos carrying the message of the project in Spanish.

Project leads worked with First Night Monterey, Greenfield Cultural Arts Center, National Steinbeck Center, Patriot Park, Greenfield, and Sol Treasures in King City to present programs in Spanish which was recognized by partners and community leaders as an important part of returning live relevant art to the Oaxacan and Spanish-speaking community in South County.

a. The project audience and presenters consisted of Oaxacan and Spanish-speaking farmworkers, and individuals residing in Monterey County in Salinas, Greenfield, and King City.
b. The live performances let artists share their lived experiences with mental health challenges and recovery.
c. The events hosted Interim Inc, Blue Zone, Catholic Charities, and Lideres Campesinas to dialogue on mental health and mental health resources with attendees during and following performances.
d. Host facilities and local performing groups made it clear to attendees that they were prepared to provide appropriate mental health resource referral information to attendees. The events were documented extensively with video and stills.

Attendees filled out surveys asking for demographic information regarding ethnicity, age, gender, arts as healing, unhappiness, anger issues, disorientation, the relative values of speaking with people in confidence, the value of social services in Spanish, and the value of a safe place to talk. The purpose of the survey was to assist them in determining if they should seek service referrals for mental health services for themselves, their friends, or their families.

Presentation Report
1. October 30, 2021-Greenfield Cultural Arts Center First Night Monterey and Mi Vida, Mi Arte, Mi Alegria Day of the Dead.

a. Number of attendees: 50-60.

b. Content of workshop performances: held outdoors with an introduction to the project by the coordinator and Greenfield Lyricist Andrés Hernandez. Performers included Arcoiris Cultural Folklorico, Greenfield High Choral Trio, and ranchera singer Alex Sings.
c. Content of dialogue with audience: Greenfield High School Music Teacher stresses the value of art as healing especially coming out of Covid lockdowns. Folklorico instructor stresses the value of joy in dance and the importance of artistic social activities for children. Alex Sings promoter shares how his music saved him from depression after an injury as a farmworker in Greenfield. The coordinator invites everyone to more presentations promoting art as healing and accessing social services when you need them.
d. The presentation offered an open invitation for the audience to get referrals through school counselors and Greenfield Art and Culture Center instructors.
e. The project doesn't provide social workers at events to get an immediate number of individuals reporting attending or attempting to attend referred service. Mental health intervention through the arts is an incremental consciousness-raising transformational learning process that leads one to make better life choices in pursuit of happiness.
f. Andrés Hernandez approaches participants and the audience members one-on-one as someone whose substance abuse after an accident in the fields almost destroyed his life. Alliance on Aging helped him get the help he needed.

Presentation Report
2. March 31, 2022, National Steinbeck Center Cesar Chavez Make a Difference Day
a. Number of attendees: 20
b. Content of workshop performances: Poetry by Josefina Garcia. Songs and poems by Andres Hernandez. Comments on art as intervention and the value of social services.
c. Content of dialogue with audience: Poet Josefina Garcia shares her book on her lifetime of struggle as immigrant farmwork and businesswoman to achieve fulfillment in collaboration with the United Farmworkers and Salinas Living Poetry and Prose Project. She tells how she was assisted by Rosa Elena, a poet whose help from BHS helped her to deal with her undiagnosed mental issues and become Josefina's mentor. Andres Hernandez shared his songs and poems and how Alliance for the Aging's Irene Valverde got him the help he needed and connected him with Salinas Living Poetry and Prose Project to publish seven books of his poems, cumbias, rancheras, etc.
d. Number and type of referrals provided: The presentation offered an open invitation for the audience to get referrals through school counselors and Greenfield Art and Culture Center instructors.
e. Number of individuals reporting attending or attempting to attend referred service(s). The project doesn't provide social workers at events to get an immediate number of individuals reporting attending or attempting to attend referred service. Mental health intervention through the arts is an incremental consciousness-raising transformational learning process that leads one to make better life choices in pursuit of happiness.
f. Qualitative remarks: The comments by Josefina and Andres speak to the value of art and support to bring someone to get the help they need. In Rosa's case getting her poems published in Voces de la Calle changed her life and led her not only mental health support, but housed a AA degree from Hartnell, four published poetry books, and confidence to become an activist against sex trafficking.

Presentation Report
3. May 15, 2022, Fiesta de las Madres, Patriot Park, Greenfield
a. Number of attendees: 70 41 Surveys filled out.

b. Content of workshop performances: MCs Andres Hernandez and Pilar Mendoza, Folklorico dance by Arcoiris Cultural, mariachi music and songs by Mariachi Juvenile Jaliscience, poetry and song by Josefina Garcia, songs with live mariachi ensemble by Alex Sings and Patricia Alejandres. Comments on art as intervention and the value of social services. Raffle for prizes and a refurbished computer donated by Loaves, Fishes, and Computers.

c. Content of dialogue with audience: Pilar Mendoza introduces the program with a reminder of how important the arts are and social services for those who need them. Andres Hernandez greets friends in the audience from his days as a youth soccer coach and how art and social services have helped him through troubles.

d. 50 attendees filled out surveys asking for demographic information regarding ethnicity, age, gender, arts as healing, unhappiness, anger issues, disorientation, the relative values of speaking with people in confidence, the value of social services in Spanish, and the value of a safe place to talk. The purpose of the survey was to assist them in determining if they should to seek service referrals for mental health services for themselves, their friends, or their families.

e. The presentation offered an open invitation for the audience to get referrals through school counselors and Greenfield Union School District Counselors, Greenfield Art and Culture Center instructors. and Greenfield Science Center Staff. Mental health intervention through the arts is an incremental consciousness-raising transformational learning process that leads one to make better life choices in pursuit of happiness.

f. Qualitative remarks: The group's decision to celebrate a traditional Mexican Mothers Day celebration in the park was seen as an example of the community reclaiming their culture and art as we move through Covid. Survey comments referred to the ambiance, "Knowing my culture." "Walk and talk about feelings."Benefits for my autistic daughter."

Presentation Report

4. May 22, 2022, Free Music, Poetry, and Songs in the Park, Patriot Park, Greenfield

a. Number of attendees: 65

b. Content of workshop performances: MCs Jorge Flores and Pilar Mendoza, Folklorico dance by Arcoiris Cultural, Poetry and song by Josefina Garcia, poetry and song by Josefina Garcia, Mixteca and Spanish poetry by Jorge Flores, live music and Oaxacan "chilena" dance mix by Daniel Rubio. Spanish language comments on art as an intervention and the value of social services by Pilar Mendoza and Jorge Flores which included a ten-minute piece on accepting his Oaxacan heritage after growing up in Tiajuana. Raffle for prizes and a refurbished computer donated by Loaves, Fishes, and Computers.

c. Content of dialogue with audience: Pilar Mendoza introduces the program with a reminder of how important the arts are and social services for those who need them and the value of more boys taking up Folklorico dance. Jorge Flores talks about the transformative value of becoming yourself, transformative learning through art, and the value of social services that have helped his friends and family.

d. 50 attendees filled out surveys asking for demographic information regarding ethnicity, age, gender, arts as healing, unhappiness, anger issues, disorientation, the relative values of speaking with people in confidence, the value of social services in Spanish, and the value of a safe place to talk. The purpose of the survey was to assist them in determining if they should seek service referrals for mental health services for themselves, their friends, or their families.

e. The presentation offered an open invitation for the audience to get referrals through school counselors and Greenfield Union School District Counselors, Greenfield Art and Culture Center instructors, and Greenfield Science Center Staff.

f. Qualitative remarks: The group's decision to celebrate and dance to traditional Oaxacan music in the park as we move through Covid. Survey comments referred to the ambiance,

"Music, Sun, Park." The Greenfield police enjoyed talking to the presenters and the audience. Interim joined us again to help with surveys and raffle activities as well as information on how to get referrals to their mental health services.

Presentation Report

5. June 5, 2022, Free Music, Poetry, and Dance for the Whole Family

a. Number of attendees: 40. 34 surveys filled out

b. Content of workshop performances: MCs Jorge Flores and Pilar Mendoza, Folklorico dance by Arcoiris Cultural, Mixteca and Spanish poetry by Jorge Flores, live music and Oaxacan "chilena" dance mix by Daniel Rubio. Spanish language comments on art as an intervention and the value of social services by Pilar Mendoza, Michael Houston, and Jorge Flores. Raffle for prizes frame art.

c. Content of dialogue with audience: Pilar Mendoza introduces the program with a reminder of how important the arts are and social services for those who need them and the value of more boys taking up Folklorico dance. Jorge Flores talks about the value of social services, which have helped his friends and family. Michael Houston called everyone's attention to the Art as Intervention mural for the Art as Intervention at the Youth Center. He noted that the mural project has greatly reduced recidivism among incarcerated youth who are turning their lives around. He reminded parents that school counselors are there to assist them to get help when their family needs it. The raffle included culturally relevant art pieces.

d. 34 attendees filled out surveys asking for demographic information regarding ethnicity, age, gender, arts as healing, unhappiness, anger issues, disorientation, the relative values of speaking with people in confidence, the value of social services in Spanish, and the value of a safe place to talk. The purpose of the survey was to assist them in determining if they should seek service referrals for mental health services for themselves, their friends, or their families.

e. 34 attendees filled out surveys asking for demographic information regarding ethnicity, age, gender, arts as healing, unhappiness, anger issues, disorientation, the relative values of speaking with people in confidence, the value of social services in Spanish, and the value of a safe place to talk. The purpose of the survey was to assist them in determining if they should seek service referrals for mental health services for themselves, their friends, or their families.

f. Qualitative remarks: As always, the Probation Department 6 x9 mural of Elkhorn Slough made a great backdrop to the event. Sol Treasures staff and volunteers and My Life, My Art, My Happiness leads helped with surveys and raffle tickets. Presenters and leaders spoke with individuals and family groups about arts and the benefits of help from social services. with the warm and friendly environment of the backyard concert. They also answer questions on how to get referred to social and mental health services.

Presentation Report

6. June 12, 2022, Ranchera Singers and Poetry at Sol Treasure King City

a. Number of attendees: 35

b. Content of workshop performances: MCs Andres Hernandez and Pilar Mendoza, Folklorico dance by Arcoiris Cultural, mariachi songs performed by Patricia Alejandres, Carlos Rodriguez, and Juana Rojas, poetry by Josefina Garcia. Comments on the value of friendship and family support and art as intervention and the value of social services. The raffle for prizes included framed regional photographic art and items from the Sol Treasures shop.

c. Content of dialogue with audience: Pilar Mendoza introduces the program with a reminder of how vital the arts are and social services for those who need them. Andres Hernandez greets friends and introduces the performers who will perform the songs he wrote when he was in prison and since. Social services have helped him through troubles.
d. 27 attendees filled out surveys asking for demographic information regarding ethnicity, age, gender, arts as healing, unhappiness, anger issues, disorientation, the relative values of speaking with people in confidence, the value of social services in Spanish, and the value of a safe place to talk. The purpose of the survey was to assist them in determining if they should seek service referrals for mental health services for themselves, their friends, or their families.
e. M The presentation offered an open invitation for the audience to get referrals through school counselors, Rosemary Soto of the Health Department at 620 Broadway St # N, King City, (831) 386-6899
f. Qualitative remarks: Sol Treasures was a very hospitable site and looks forward to doing more community building, fun, and healing through the arts both in King City and throughout the county with art, music, and friendship.

Appendice – Survey Results
153 attendees filled out surveys.

Ethnicity
24 No answer, 112 Mexicano/Mexicana, 44 Latin American, 8 Indigenous, 6 White

Age in Years
57 No answer, 17 0-12, 7 13-20, 25 21-35, 38 36-and up

Gender
54 No answer, 55 Female, 39 male

1. Would you come to another Mi Vida, Mi Arte, Mi Alegria Presentation?
3 No Answer, 141 Yes, 2 No

2. Do you have friends or family that are very unhappy?
32 No Answer, 35 yes, 86 no

3. Do you have friends or family that are quick to anger?
27 No Answer, 44 Yes, 72 No

Do you have friends or family that have mixed up feelings or thinking?
No Answer 27, 35 Yes, 84 No

What would make them feel better?
4. Talking with people they trust.
47 No Answer, 114 Yes, 0 No

5. Help in Spanish with Social Services
73 No Answer, 82 Yes, 0 No

Would you invite other people to My Life, My Art, My Happiness Programs?
8 No Answer, 144 Yes, 5 No

Door to Hope/'Circle of Security' Program for Farmworkers

Door To Hope
Micro-Innovation Grant 2021-2022 Circle of Security

B. Project Summary Report:

a. Total number of participants: 32 total participants.

b. Demographics of total number of participants: All participants were of Hispanic/Latino descent. 22 participants were of Indigenous descent (19 Triqui and 3 Mixteco).
18 were South County residents, 11 from Salinas, 2 from Marina, 1 from Sand City.
22 spoke an indigenous language as their primary language (19 Triqui and 3 Mixteco)
10 participants spoke Spanish as their native language
All participants were of low socio-economic status
A majority of participants were farmworkers
3 participants had an open CPS case
4 fathers participated consistently

c. Total number of MH referrals provided to participants: 12 referrals were made to mental health services. Referrals were made to MCBH through the Access Line (3 referrals), Community Human Services (6 referrals made specifically for their non-insured MH program), Beacon Health (1 referral), DTHs Behavioral Health Integrated Program (1 referral) and a private insurance provider (1 referral).

d. Type of referrals provided to participants: Aside from the 12 referrals made directly to mental health services Florentina (case manager) made referrals to other parenting programs such as the F5 Collaboratives, community playgroups, Abriendo Puertas, Positive Discipline and Parents As Teachers. She also referred to CHISPA, MC Housing Resource Center, MC Food Bank, local food distribution, diaper drives, MAOF (childcare), Go Kids (childcare), and financial assistance resources such as United Way 211, and national programs providing financial support.

e. Number of participants that utilized referrals (e.g. attended at least one appointment)
9 participants were successfully connected to mental health services and continue to regularly see their therapist.

f. Description of successes, challenges and barriers associated with this project, in relation to the stated goals of promoting greater access to mental health services by unserved and underserved Hispanic/Latino communities, and contributing to statewide learning under the Innovations component to identify potential promising practices. (i.e. If this program was regularly offered to this population of focus, would it contribute towards improved/positive perceptions of mental health services, and/or promote greater help-seeking behavior? And, what else was learned as part of this project that can inform mental health services in becoming more culturally responsive and engaging for these unserved and underserved populations?)
Successes in meeting goal:

Offering Circle of Security classes to the unserved and underserved Latino communities was a fundamental way to begin exploring basic mental health components and information with a population that has limited access to mental health education or resources. We found that when parents understand what positive relationships look like and are able to learn about their own traditional mental health knowledge and practices they are then able to connect their experiences to their needs and better understand the resources available to them to address such needs/challenges.

This leads to another success we had in meeting the goal. By offering COS to families of different cultural backgrounds (Mexican, American, and Indigenous) we were able to explore the many ways in which different communities engage with their mental health needs and wellbeing. Because COS first explores what a person already knows or has experienced around positive relationships, we were able to learn the different practices parents already use to process mental health challenges. For example, we learned that the Triqui community historically participates in "sweat lodge" like rituals when needing to heal their body and spirit. They also have leaders that guide a person through going back to painful memories or experiences that "robbed" them of their positive spirit and process those negative experiences to bring their positive spirit back to them. Together we learned that all cultures and communities already have mental health ideas and rituals and now need spaces in their new communities in Monterey County to practice their native traditions that help them heal their mind and body. When people have resources in their communities that reflect who they are and where they come from they are more willing to accept help and support when they need it.

This program works because it not only respects cultural differences but it allows adaptations to incorporate unique cultural values, learning practices, and traditions to guide parents in reflecting on their own ideas about relationships and mental health and come up with their own goals and objectives for their own families.

All of these successes were possible because we were able to offer services to families in their own language and using culturally appropriate methods of learning such as storytelling and visual aids. Both Triqui speaking groups shared having a very positive learning experience as they listened to new information in their own language and were able to discuss, reflect and ask clarifying questions in the language they felt most comfortable in. Having groups specifically for Triqui speaking families helped create a safe and comfortable environment where parents felt safe to speak and become vulnerable enough to reflect and connect with new ideas and information. Parents shared feeling connected to other parents from their same communities and able to learn from each other because they understood where they were coming from.

In an ideal setting, COS would be offered consistently and permanently throughout the county all year long, specifically in the most isolated and underserved parts of the county, and offered in the many languages spoken in our county and facilitated by members of those specific communities. Classes would ideally be in person, with virtual options available during the agricultural season, and include free child care and meals.

COS would be a great way to create more positive and inclusive spaces for our communities to learn about their own relationships with mental health and wellbeing and together reflect on their needs and ability to reach out for support when needed. We can then work together to assure that our systems of care include mental health services and treatments that address the unique needs of our diverse communities. When families have a better understanding of their needs and see services in their communities that value their history and traditions they will be more able and willing to seek out help when needed.

COS is also the perfect venue for our systems of care to learn more about the needs of each community we set out to serve. First we must understand where people come from to understand the root of their behavior. We cannot expect people to simply accept our services when 1. our services do not cater to their

language, culture, location, etc. and 2. our services do not understand or value the knowledge and practices they already have to address their wellbeing. When we create a health system that creates spaces inclusive of and tailored to the specific needs of all of the different cultural sectors of our county we will automatically foster a community of help-seekers that trust in and understand the services available to them.

This project helped us realize that as a system we must first invest in educating ourselves on the needs of those we are trying to recruit and serve. Creating safe and reflective spaces to have open and vulnerable conversations helped us learn about the people of our community and understand that our Western ideas of mental health treatment will not work with all populations. It helped us see that almost all cultures already have their own mental health practices and treatments that we know almost nothing about. We need to start there. Instead of investing resources in recruiting and trying to convince everyone that our services are the answer to everyone's mental health challenges, we must invest in learning more about what our communities already do and need to promote their own wellbeing. We must invest in the education and leadership of culturally congruent leaders that can lead the implementation of culturally responsive mental health treatments all over Monterey County. Our county residents already know what they need, we must listen to understand those needs and provide the culturally specific treatments and services that promote healthy and productive lives.

Circle of Security Session 2 Report

a. ***Meeting Details***

The Circle of Security Program is an eight-week session class that began on January 19, 2022 and ended on March 9, 2022. The Circle of Security concept focuses on parenting attachment and creating positive relationships. Sessions were provided via zoom once a week for two hours, Wednesdays from 12:00pm to 2:00 pm. Attendance sheet attached.

b. ***Number of participants***

7 parents participated for 2 or more sessions. All participants were connected to multiple agencies, including mental health services, by the Care Coordinator Florentina Sanchez. Florentina connected with all participants outside of the COS session to address individual family needs and connect to county-wide services.

c. ***Demographics of participants (consistent with MHSA regulations)***

All participants reside in Greenfield and all are of Oaxacan Indigenous decent. All participants speak Triqui as a primary/native language.

d. ***Methods of participant recruitment***

Fliers and referral forms were shared with partner South County agencies such as Centro Binacional Para el Desarrollo Indígena Oaxaqueño, Monterey County Probation Department (CAP), GUSD, as well as Door To Hope programs such as the DTH/F5 Collaborative and the Behavioral Health Integrated Program (BHI) to reach parents from the native Mexican communities whose first language is Triqui Of Copala. Fliers were also distributed to county wide agencies such as MCBH, AUSD, Go Kids, MCHD, etc.

Fliers and referrals were created in English and Spanish as there is no Triqui written language. An image of an indigenous family was highlighted on the flier to illustrate positive parent-child engagement/attachment. Fliers and referral forms attached.

e. ***Number and type of mental health service referrals provided to participant (referral utilization information to be included in Project Summary Report)***

Two moms were connected to Community Human Services for Mental Health services. CHS is the only agency in the county who accepts and provides MH services for the undocumented population. Their services are limited to English/Spanish and only at their Salinas offices.

f. ***Summary of successes***

The biggest success with this COS session is creating a space for indigenous/immigrant families to not only learn our western ideas and practices around mental health but most importantly, for us as providers to learn more about what our communities already know about mental health and what they already practice within their own cultures to support their own and their families' mental health and spirituality. We learned so much from reflecting on universal parenting practices and how these parents connect with their children and what they do when they become overwhelmed and stressed. The facilitators created a space where the parents were the experts on their own children and families and this class supported them in reflecting on these practices to determine what worked and what they wanted to improve upon. Parents felt respected and able to share their strengths and practices because the COS framework is based on valuing parents as they come and working with the knowledge they already have. The indigenous cultures already have a lot of spiritual practices that support their wellbeing. It is would be helpful for us as a community to learn more about what these are and support them in creating spaces for them to continue their rituals and practices they left behind. Being able to participate in their own cultural traditions, such as sweat lodges and traditional art, can assure they are constantly taking care of their own mental health and wellbeing in their own ways. Spaces like COS allow us to learn from each other and together come up with creative and culturally appropriate ways indigenous families can pull from their strengths and values to stay true to themselves while also learning how to meet the needs of their children. All participants were open to learning more about attachment and building healthy relationships with their children, which are concepts that can be adapted to the specific cultural values of different communities. We would love to continue creating these types of reflective and respectful spaces where our different communities come together to learn from each other, instead of one party sharing what we may think is the "medicine" to mental health challenges.

This session the facilitators confirmed that a smaller more intimate group is crucial to create a safe space where parents built trust and vulnerability amongst each other and felt comfortable sharing personal and sensitive information with each other while reflecting on the information presented. COS International recommends no more than 10 parents in a session and with 7 parents in this session the facilitators felt all parents participated regularly and shared feeling safe and supported by other parents when sharing and asking questions. This is even more important when facilitating a virtual class as it takes more time to build trust and to feel connected to those on the screen.

Parents shared they appreciated being able to ask questions and express themselves in their native language. This assured that they really understood the information that was being shared and were able to then apply it to their own lives. They reported that Mental Health was a topic that they do not learn about or discuss with family or friends and it was essential that they first learn about it in their native language to be able to fully grasp the new concepts and ideas. The presentations were also infused with visuals and videos as many of these families have limited Spanish and are illiterate. Florentina also changed some of the presentation verbiage to include words, phrases and saying commonly used and understood by this community.

Having the class virtually allowed them to be more consistent as they did not have to worry about leaving their home and all of the challenges that come with that, including getting kids ready etc.

Having two facilitators was helpful in many ways. They were able to help each other prepare for each session. They supported each other in starting conversations and engaging parents to join a conversation. One would take care of the zoom logistics and attendance while the other kept the session material moving.

Having a Care Coordinator was essential in being able to connect with each parent individually before or after each session. Florentina met with each parent before the start of the class to assure everyone had the ability to connect to the virtual class and delivered class materials. She then connected with them after each session to discuss what they had learned and to get to know each family individually to determine any potential needs for community referrals such as mental health, parenting or financial resources. Florentina would then assure they connected and were able to receive the services they needed. Florentina would follow up with resources when barriers arouse, such as assuring translation or transportation services.

g. ***Challenges and barriers:***

We scheduled the class in the morning as many families do not work in the agricultural off season (Nov-March). In early March, however, some of the participants returned to work and were not able to complete the class.

Several of the participants struggled to stay connected in the class as they used their cell phones and had limited bandwidth or internet data and were kicked off throughout the sessions. South County also has poor internet reception which made it difficult for all parents to stay connected, often having poor connectivity.

The biggest barrier we are encountering across our DTH programs, including COS, is the lack of mental health services to support the undocumented. Initially, at the beginning of the fiscal year, we were optimistic as CHS shared they had specific funding and therapists to provide mental health services to the undocumented population. We quickly referred several of our DTH clients, including two from COS, and their capacity quickly reached its limit. They then lost one of their clinicians and until now are no longer taking referrals. Both clients that were referred to CHS from this COS session remain on their waitlist. They are both in the mild-moderate category so neither MCBH nor Beacon can provide services.

Another barrier is the lack of Mental Health services in South County. Both moms referred to CHS live in Greenfield and do not drive. Their husbands do not support their participation in mental health services and will not drive them to Salinas for therapy. Unfortunately, CHS does not do home visits or have a location to provide services in South County. Both moms prefer in person services as their Spanish is limited and it is difficult to fully understand a Spanish speaker over the phone or virtual services.

Yet another barrier is the lack of services provided in indigenous languages. Interpretation/translation is also an issue. When initiating services with CHS they informed us that they were unable to translate consent forms as Triqui is not a written language and they did not feel comfortable interpreting when the family's grasp of Spanish is very limited. CHS is currently in the process of getting approval from MCBH to translate to non-English/Spanish speakers with the help of interpreters. Our COS clients remain on their waitlist for this reason. The limited knowledge we have about our indigenous communities and what their cultural values and practices around mental health and wellbeing are is a significant challenge. If we knew more about what they already do to address social and emotional challenges we might be able to support them in creating spaces for them to have access to more culturally congruent treatments. We must step away from the perception that therapy is the only solution for mental

health wellbeing and embrace the diverse treatments and practices that have been supporting families throughout the world from the beginning of time.

h. ***Any relevant information pertaining to participant satisfaction, and/or change in perception or understanding of mental health and mental health services***

The participants shared the following indicating that they were reflecting on and analyzing what they were learning in their COS sessions:

- "I used to yell at my daughter when she'll cry and she would cry even more, but now when I speak softly to her and try to understand her with questions, she'll calm down."
- "My daughter likes to explore a lot, I thought she was naughty but now I know she just wants to learn."
- "I've noticed that being present and supporting my child's exploration makes her feel happy and that makes her want to explore even more."

By sharing this we understood that participants changed their perception on how they acted before and how they are see now. They also opened up to us to share what they feared and the painful experiences that shaped them. As one of the clients shared; "I was detained by immigration when I crossed from Mexico to the United States. I was locked up for 3 months. During the first weeks I felt sad, worried and alone. I didn't understand anything of what was going on. I just knew I was in the hands of the green uniform people. In this place I found a group of Salvadorans who were also in the same situation as me. I didn't understand any word of what they were saying but with their action and sweetness of tones I felt accompanied in my feelings and made me feel calmer." pointing out her understanding of the importance of accompanying feelings.

"I have hate in my heart because of how I was treated as a child by my parents. And sometimes I feel like I'm doing the same with my children and I'm afraid of losing them."

"I can't control my anger. I scream at them without thinking first. Small things make me angry and I want to change my behavior to support my kids."

Creating a familiar and comfortable space for families to join helped in communicating new concepts and information. Families reflected on the new information and how it pertained to their own lives. They shared how they implemented what they were learning in their own homes and the progress they were seeing in creating more positive environments in their homes. Most parents wanted to continue learning about positive parenting/discipline information and asked for referrals to playgroups, Parent as Teachers, and our F5 Collaborative programs. Some were able to accept that they struggled in some areas and wanted to learn more about how mental health treatment could continue to help them explore their challenges and provide tools to address them. It was astonishing to see how when we begin by providing basic education and culturally responsive spaces for families to gather to reflect and discuss their own experiences most parents begin to seek out more support on their own. We must continue to empower all of our county parents as any type of treatment only works when the client fully understands its purpose and is committed to the process they understand.

Circle of Security Session 3 and 4 Report:

The third session was split into two as the number of interested participants exceeded the maximum amount of participants recommended by COS International. COS International recommends no more than 8-10 participants in zoom sessions.

Session 3 – Wednesday evenings from 4pm – 6pm via zoom. Started April 6, 2022 to May 25, 2022. Session facilitated in Spanish

Participants: 10 participants attended the first or second session. 8 participants attended regularly. Referrals were received from partnering agencies such as the Parents as Teachers program from Door To Hope and the Monterey County Probation Department's Child Abuse Prevention Advocacy Program (CAP).

Demographics: All participants spoke Spanish. 2 were bilingual Spanish/English and 3 was bilingual Spanish/Mixteco. 7 spoke Spanish as their primary language. All participants were of Mexican descent.
3 participants were of Indigenous descent.
6 participants were Salinas residents, 1 a Marina resident and 1 a Greenfield resident.

Methods of participant recruitment: COS fliers (attached) were emailed to Door To Hope agency programs as well as outside agencies and programs such as Centro Binacional, MC Probation Department, MC Children's Behavioral Health, F5 Collaboratives, MC Public Health Nursing, MC Parenting Connection etc. As a result, the partner agencies made 25 referrals. The high number of referrals was taken into consideration by splitting them to create an additional group that started on April 6, 2022 (Wednesday Classes). The split was done by following COSP curriculum recommendation of group sizes, which is a maximum of 8-10 caregivers in a reflection group.

Number and type of mental health service referrals provided to participant
All participants were given Mental Health education and resource information as well as connected to resources to support any area of their family wellbeing. This included additional parenting programs such as Abriendo Puertas and Positive Discipline.
1 participant was connected to Mental Health Therapy through her private insurance.

Summary of successes, challenges, barriers experienced during session
Most of these participants were parents with children approximately 7 to 11 years of age and had experience parenting. As parents continued with the class, parents shared that even though they had expertise as parents with older kids and toddlers, there are always things to open their eyes to. For example, one of the parents has shared that emotions were not spoken in the family that made him closed off to emotions but is now realizing how his lack of emotions is negatively impacting his children's emotional development. By providing COS classes to this group of participants it will enhance parents' knowledge that by not providing attachment to an infant or in early childhood will affect psychopathology of the infant or child throughout their lives.
Challenges: The participants in the COS class used their cell phones with limited data, which is not good enough to access the internet or videos. During the class participants were dropping and re-entering from the class as they lost and regained reception and/or data. Low internet data created misunderstandings and confusion in the COS sessions. Or sometimes they couldn't

connect because the internet was slow. At some point, the same thing happened with the facilitators where the internet was slow or had no connections.

Another challenge was that the COSP videos target parents of younger children and most participants in this group had older children and teens. Though the information still applied, it would be nice to include more videos that all parents can directly relate to.

***Session 4*:** Friday evening from 5pm-7pm via zoom. Facilitated in Spanish. Started April 1, 2022 and ended May 20, 2020. Sessions began from 4pm-6pm but were changed to 5pm-7pm as parents went back to work or increased the amount of hours they needed to work and were getting home later in the evening.
Participants: 9 participants began and ended this 8 week session. All referrals came from internal Door To Hope programs or partnering agencies.
***Demographics*:** 4 participants were from Salinas, 2 from King City, 1 from Greenfield, 1 from Marina and 1 from Sand City. 8 spoke Spanish as their native language, 2 were bilingual Spanish/English and one participant spoke Mixteco as their native language and Spanish as their second. 5 participants are agricultural farmworkers.
Methods of participant recruitment: Fliers and referral forms were shared with partner agencies such as Centro Binacional para el Desarrollo Indígena Oaxaqueño and the Monterey County Probation Department (CAP) as well as Door To Hope Programs such as the DTH F5 Collaborative and the Behavioral Health Integrated Program (BHI) to reach parents that are bilingual or monolingual Spanish speakers. As a result, the partner agencies made 25 referrals. The high number of referrals was taken into consideration by splitting them to create an additional group that started on April 6, 2022 (Wednesday Classes). The split was done by following COSP curriculum recommendation of group sizes, which is a maximum of 8-10 caregivers in a reflection group.
Number and type of mental health service referrals provided to participant:
All participants were given Mental Health education and resource information as well as connected to resources to support any area of their family wellbeing. This included additional parenting programs such as Abriendo Puertas and Positive Discipline. Basic resources were also shared such as the MC Food Bank, and the MC Housing Resource Center as well as the Salinas Adult School.
7 participants were connected to Mental Health services including MCBH, Community Human Service, Door To Hope's Behavioral Health Integrated Program, and Beacon Health.

Summary of successes, challenges, barriers experienced during session
The Circle of Security is a curriculum that heals, restores, and strengthens external and internal relationships based on reflections. In this curriculum, parents can reflect on the attachment of caregivers as essential for infants, toddlers, and preschoolers to develop. The caregiver's attachment is necessary for these inexperienced children to feel secure and explore the world, emotions, wisdom, etc. As parents learn the importance of attachment, caregivers recall memories of actions and decisions of daily life. They also explore parenting actions that can bring long-term results in the child's behavior in the future.
As caregivers feel safe and secure, caregiver's started to share stories related to the COS curriculum that brought them together; Stories such as painful memories of their childhood, overwhelming moments that caused ruptures in their relationships as well coping with the loss of a loved one and trying to protect a fragile child from emotional pain. COS helps parents reflect and modify parenting styles with children as well as helping parents forgive themselves for

things that they didn't realize was causing their children harm. As a result, this also increased the caregiver's awareness of the importance of showing empathy and positive attribution to their child.
Though some parents wanted to experience this class in person, it was helpful to have a virtual class as we were able to recruit families from throughout Monterey County. Families from all parts of Monterey County joined every week and were able to log on in their cars after work or from home without needing day care services.
Some of the challenges were pursuing parents for therapy services. Participants expressed their need for therapy by sharing stories of difficult times in their lives, creating an environment of mutual support. Barriers to being admitted to therapy services were the lack of time and fear of losing their job due to appointments with therapy services. Other challenges were unstable internet connections. The participants in the COS class used their cell phones with limited data, which is not good enough to access the internet. Low internet data created misunderstandings and confusion in the COS sections. Or sometimes they couldn't connect because the internet was slow. At some point, the same thing happened with the facilitators where the internet was slow or had no connections. Lastly was that the COSP video was not suitable for the participants. This is because the videos highlight the exploration of the circle of security from newborns to children. This conflicted with the ages of the participants' teens.

Any relevant information pertaining to participant satisfaction, and/or change in perception or understanding of mental health and mental health services

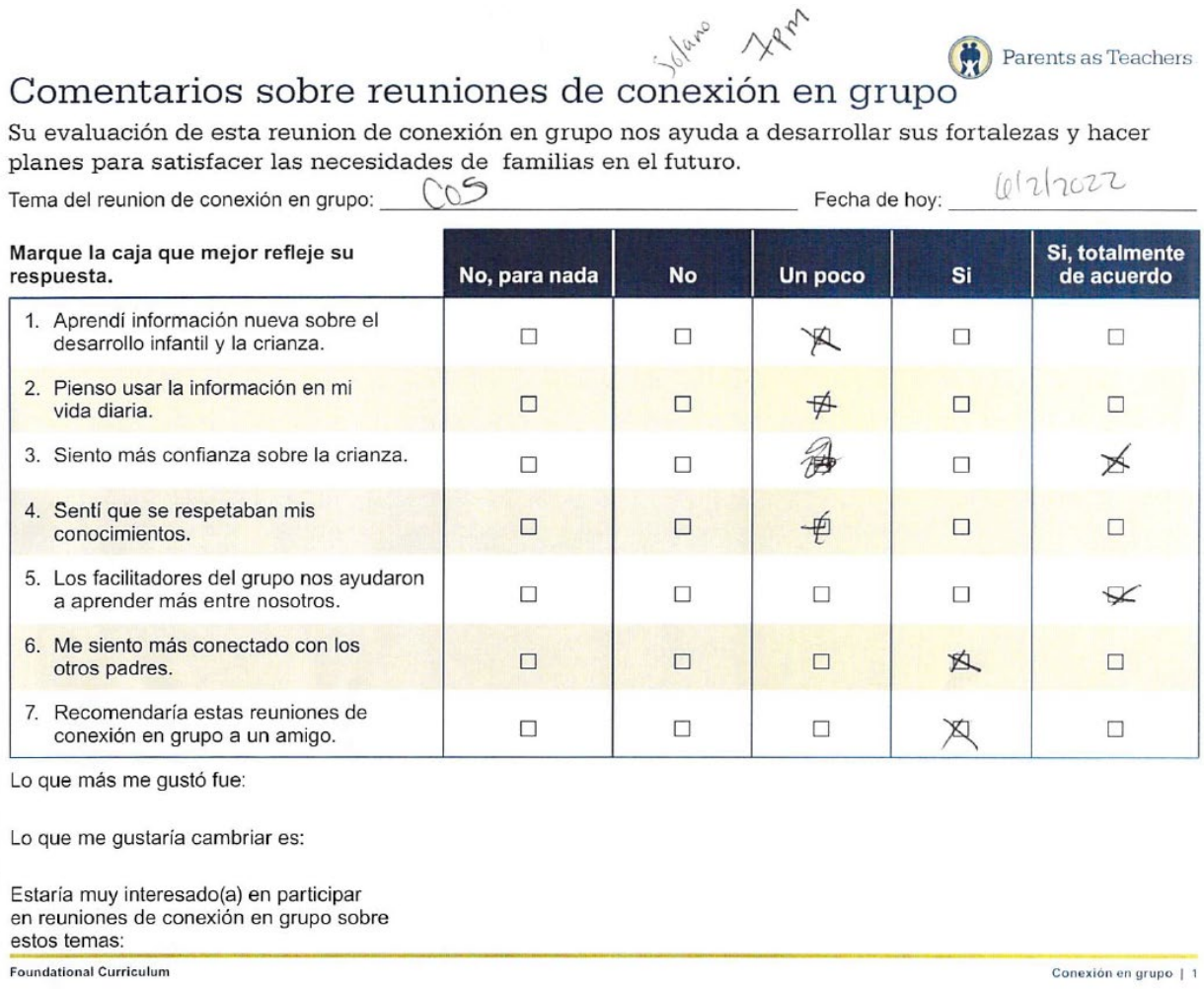
We have attached our parent satisfaction surveys that were completed with 12 participants a few days after both sessions ended. Here are some translated quotes from those surveys.

What did you enjoy the most from the COS Program:

"The conversations with other parents that are all going through the same experiences."
"That they made us feel very comfortable and they helped us learn"
"What I liked the most was the theme of wiser, bigger, stronger, kinder"
"How to talk to my kids"
"Everything. The theme of wiser, stronger, bigger, kinder. I learned the importance of analyzing and reflecting on my feelings and emotions. I am a person that gets mad easily. Now I analyze my feelings before responding."
"Everything they taught I liked"
"Emotions. I am more conscious of what I say and do with my kids"
"I learned how to connect and identify with other parents"
" I would like classes to be in person"
"I liked to learn about child development. I didn't know that when they play they are exploring."
"It would have been better in person but I did like it virtually as well."
We found that all parents were able to establish a sense of trust and safety and all participated by sharing their personal experiences and how they were personally connecting with the material presented. Because classes were relatively small participants got to know each other pretty well in eight sessions and all had ample time to share with the larger group or in small breakout groups.

Parents often shared their learning experiences. Many shared they had not been to a class such as COS where they were able to reflect on their own childhood experiences to understand why they

parent the way they do and understand where their values, ideas, and beliefs really come from. It was only then that they could better understand their needs. Many also shared how COS helps them reflect on their relationships with their children and all of the aspects that affect their relationships. They are then able to identify areas of growth that they want to focus on and learn strategies on how to improve their relationships with their children. They appreciated the ability to not only learn from the information the facilitators shared but most importantly from each other as they felt connected to other parents who were facing similar struggles.



Parents as Teachers

Comentarios sobre reuniones de conexión en grupo

Su evaluación de esta reunion de conexión en grupo nos ayuda a desarrollar sus fortalezas y hacer planes para satisfacer las necesidades de familias en el futuro.

Tema del reunion de conexión en grupo: COS Fecha de hoy: 6/2/2022

Marque la caja que mejor refleje su respuesta.	No, para nada	No	Un poco	Si	Si, totalmente de acuerdo
1. Aprendí información nueva sobre el desarrollo infantil y la crianza.	☐	☐	☒	☐	☐
2. Pienso usar la información en mi vida diaria.	☐	☐	☒	☐	☐
3. Siento más confianza sobre la crianza.	☐	☐	☒	☐	☒
4. Sentí que se respetaban mis conocimientos.	☐	☐	☒	☐	☐
5. Los facilitadores del grupo nos ayudaron a aprender más entre nosotros.	☐	☐	☐	☐	☒
6. Me siento más conectado con los otros padres.	☐	☐	☐	☒	☐
7. Recomendaría estas reuniones de conexión en grupo a un amigo.	☐	☐	☐	☒	☐

Lo que más me gustó fue:

Lo que me gustaría cambriar es:

Estaría muy interesado(a) en participar en reuniones de conexión en grupo sobre estos temas:

Foundational Curriculum

Conexión en grupo | 1

Parents as Teachers

Comentarios sobre reuniones de conexión en grupo

Su evaluación de esta reunion de conexión en grupo nos ayuda a desarrollar sus fortalezas y hacer planes para satisfacer las necesidades de familias en el futuro.

Tema del reunion de conexión en grupo: COS Fecha de hoy: 6/2/2022

Marque la caja que mejor refleje su respuesta.	No, para nada	No	Un poco	Si	Si, totalmente de acuerdo
1. Aprendí información nueva sobre el desarrollo infantil y la crianza.	☐	☐	☐	☐	☒
2. Pienso usar la información en mi vida diaria.	☐	☐	☐	☒	☐
3. Siento más confianza sobre la crianza.	☐	☐	☐	☒	☐
4. Sentí que se respetaban mis conocimientos.	☐	☐	☐	☐	☒
5. Los facilitadores del grupo nos ayudaron a aprender más entre nosotros.	☐	☐	☐	☐	☒
6. Me siento más conectado con los otros padres.	☐	☐	☐	☐	☒
7. Recomendaría estas reuniones de conexión en grupo a un amigo.	☐	☐	☐	☐	☒

Lo que más me gustó fue:

Lo que me gustaría cambriar es:

Estaría muy interesado(a) en participar en reuniones de conexión en grupo sobre estos temas:

Parents as Teachers

Comentarios sobre reuniones de conexión en grupo

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7. Recomendaría estas reuniones de conexión en grupo a un amigo.	☐	☐	☐	☐	☒

Lo que más me gustó fue: La Combersacion con otros padres que tabes estan pasando por lo mismo

Lo que me gustaría cambriar es: NO

Estaría muy interesado(a) en participar en reuniones de conexión en grupo sobre estos temas: Si

In Person

Parents as Teachers

Comentarios sobre reuniones de conexión en grupo

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7. Recomendaría estas reuniones de conexión en grupo a un amigo.	☐	☐	☐	☐	☒

Lo que más me gustó fue: Que nos hicieron sentir muy comodos y nos ayudaron a aprender. ☺

Lo que me gustaría cambriar es: Nada

Estaría muy interesado(a) en participar en reuniones de conexión en grupo sobre estos temas: Disciplina positiva, play group

Parents as Teachers

Comentarios sobre reuniones de conexión en grupo

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7. Recomendaría estas reuniones de conexión en grupo a un amigo.	☐	☐	☐	☐	☒

Lo que más me gustó fue: La tema de grande, fuerte, Sabio y bondadoso mas me gusto fue la de X

Lo que me gustaría cambiar es: N/A

Estaría muy interesado(a) en participar en reuniones de conexión en grupo sobre estos temas:

Overphone

Parents as Teachers

Comentarios sobre reuniones de conexión en grupo

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7. Recomendaría estas reuniones de conexión en grupo a un amigo.	☐	☐	☐	☒	☐

Lo que más me gustó fue: Como hablar con lo niños.

Lo que me gustaría cambiar es: NU

Estaría muy interesado(a) en participar en reuniones de conexión en grupo sobre estos temas:

On Phone

Parents as Teachers

Comentarios sobre reuniones de conexión en grupo

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7. Recomendaría estas reuniones de conexión en grupo a un amigo.	☐	☐	☐	☐	☒

Lo que más me gustó fue: Todo. Tema favorita. Ser grande, fuerte, sabio y bondadoso. Aprendí la importacia de analizar mis sentimientos ~~antes~~ emociones. – Era una persona que se enojaba rapido, Ahora lo analizo ante de expresarme.

Lo que me gustaría cambriar es: Nada.

Estaría muy interesado(a) en participar en reuniones de conexión en grupo sobre estos temas:

Over Phone

Parents as Teachers

Comentarios sobre reuniones de conexión en grupo

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7. Recomendaría estas reuniones de conexión en grupo a un amigo.	☐	☐	☐	☑	☐

Lo que más me gustó fue: Todo lo que enseñaron, Me gusto.

Lo que me gustaría cambriar es: No. Nada.

Estaría muy interesado(a) en participar en reuniones de conexión en grupo sobre estos temas: ~~Platformas~~

Parents as Teachers

Comentarios sobre reuniones de conexión en grupo

Su evaluación de esta reunion de conexión en grupo nos ayuda a desarrollar sus fortalezas y hacer planes para satisfacer las necesidades de familias en el futuro.

Tema del reunion de conexión en grupo: 05 Fecha de hoy: 6/2/2022

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Lo que más me gustó fue:

Lo que me gustaría cambriar es:

Estaría muy interesado(a) en participar en reuniones de conexión en grupo sobre estos temas:

Overphone

Parents as Teachers

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Lo que más me gustó fue:
~~Todo~~ Las emosiones. Aprendí el quidado de niños.
Siempre hay cosas nuevas para aprecder
Soy más cosiente de lo que digo y hago con los niños.

Lo que me gustaría cambriar es:

Estaría muy interesado(a) en participar en reuniones de conexión en grupo sobre estos temas:

Over Phone

Parents as Teachers

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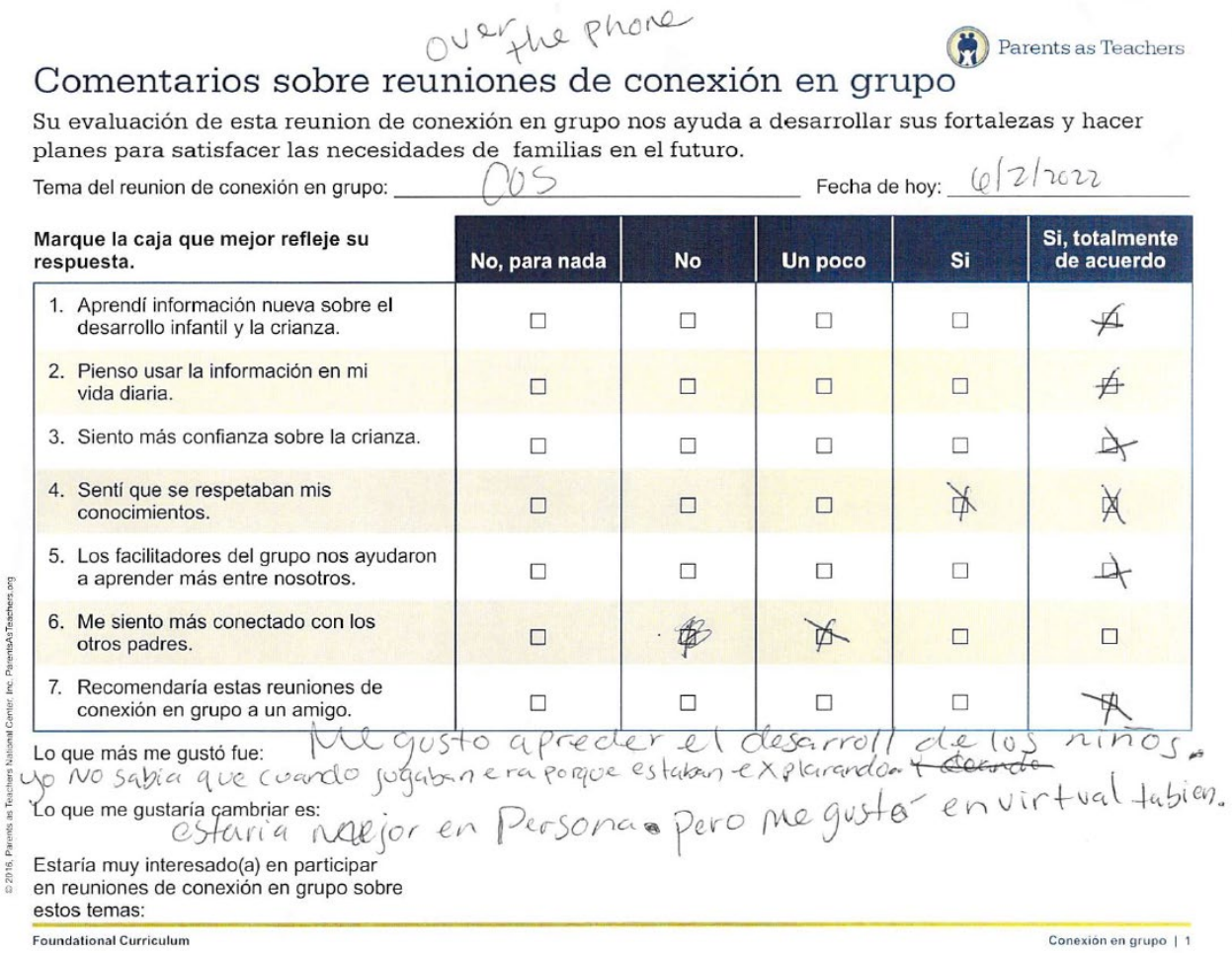
7. Recomendaría estas reuniones de conexión en grupo a un amigo.	☐	☐	☐	☐	☒

Lo que más me gustó fue: ~~Ciencia~~ De ser conectada/enclentificada con otros padres.

Lo que me gustaría cambriar es: Me gustaria que la clase fuera en persona.

Estaría muy interesado(a) en participar en reuniones de conexión en grupo sobre estos temas:



over the phone

Parents as Teachers

Comentarios sobre reuniones de conexión en grupo

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7. Recomendaría estas reuniones de conexión en grupo a un amigo.	☐	☐	☐	☐	☒

Lo que más me gustó fue: Me gusto aprecer el desarroll de los niños. yo No sabia que cuando jugaban era porque estaban explicando ~~y cuando~~

Lo que me gustaría cambriar es: estaria mejor en Persona. pero me gusta en virtual tabien.

Estaría muy interesado(a) en participar en reuniones de conexión en grupo sobre estos temas:

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Foundational Curriculum

Conexión en grupo | 1

Emeralda Owen/Public Service Announcements

Schedule of Public Service Announcements
June, 2021 (Brenda Almaraz)
Video 1: https://vimeo.com/554908227
-Theme: La Salud Mental (Mental Health General)

July, 2021 (Ruben Martin)
Video 2: https://vimeo.com/556338757
-Theme: Servicios para jóvenes y niños (Services for youth and children)

August, 2021 (Erandi García)
Video 3: https://vimeo.com/556374055
-Theme: El duelo (Grief/Hospice Giving Foundation)

September, 2021 (Isabel Bernal)
Video 7: https://vimeo.com/558232066
-Theme: Prevencion del suicidio (Suicide Prevention)

Monterey County Behavioral Health

Micro-Innovation Grant

PSA Project in Spanish by

Esmeralda Owen

2020 - 2021

October, 2021 (Fernanda Ocaña)
Video 4: https://vimeo.com/556396951
-Theme: La violencia domestica (Domestic Violence)

November, 2021 (Iván González)
Video 5: https://vimeo.com/556412487
-Theme: La depresion (Depression)

December, 2021 (Isabella Hernández)
Video 6: https://vimeo.com/556421462
-Theme: Los cuentos (Story-telling)

January, 2022 (Mónica Sánchez)
Video 9: https://vimeo.com/558292258
-Theme: La depresion post-parto (Post-partum depression)

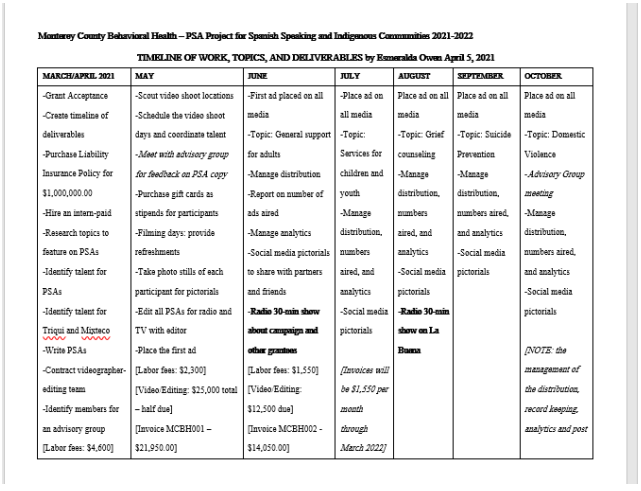
February, 2022 (Arly Lara)
Video 8: https://vimeo.com/557824748
-Theme: Relaciones saludables (Healthy relationships)

March, 2022 (Maricarmen González)
Video 11: https://vimeo.com/558780718
-Theme: La salud de la mujer (Women's health)

April, 2022 (Dulce Silva)
Video 12: https://vimeo.com/559246650
-Theme: El abuso infantil (Child abuse)

May, 2022 (Ericel Jimenez)
Video 10: https://vimeo.com/558769676
-Theme: Mes de la salud mental (Mental Health Awareness Month)

Timeline



Monterey County Behavioral Health – PSA Project for Spanish Speaking and Indigenous Communities 2021-2022

TIMELINE OF WORK, TOPICS, AND DELIVERABLES by Esmeralda Owen April 5, 2021

MARCH/APRIL 2021	MAY	JUNE	JULY	AUGUST	SEPTEMBER	OCTOBER
-Grant Acceptance -Create timeline of deliverables -Purchase Liability Insurance Policy for $1,000,000.00 -Hire an intern-paid -Research topics to feature on PSAs -Identify talent for PSAs -Identify talent for Triqui and Mixteco -Write PSAs -Contract videographer-editing team -Identify members for an advisory group [Labor fees: $4,600]	-Scout video shoot locations -Schedule the video shoot days and coordinate talent *-Meet with advisory group for feedback on PSA copy* -Purchase gift cards as stipends for participants -Filming days: provide refreshments -Take photo stills of each participant for pictorials -Edit all PSAs for radio and TV with editor -Place the first ad [Labor fees: $2,300] [Video/Editing: $25,000 total – half due] [Invoice MCBH001 – $21,950.00]	-First ad placed on all media -Topic: General support for adults -Manage distribution -Report on number of ads aired -Manage analytics -Social media pictorials to share with partners and friends **-Radio 30-min show about campaign and other grantees** [Labor fees: $1,550] [Video/Editing: $12,500 due] [Invoice MCBH002 - $14,050.00]	-Place ad on all media -Topic: Services for children and youth -Manage distribution, numbers aired, and analytics -Social media pictorials *[Invoices will be $1,550 per month through March 2022]*	Place ad on all media -Topic: Grief counseling -Manage distribution, numbers aired, and analytics -Social media pictorials **-Radio 30-min show on La Buena**	Place ad on all media -Topic: Suicide Prevention -Manage distribution, numbers aired, and analytics -Social media pictorials	Place ad on all media -Topic: Domestic Violence *-Advisory Group meeting* -Manage distribution, numbers aired, and analytics -Social media pictorials *[NOTE: the management of the distribution, record keeping, analytics and post* *of pictorials will be monthly]*
NOVEMBER	DECEMBER	JANUARY 2022	FEBRUARY	MARCH	APRIL	MAY
-Place ads -Topic: Depression **-Radio 30-min show**	Place ads -Topic: Power of storytelling in kids	Place ad -Topic: Post-Partum depress. **-Radio 30-min show**	Place ad on all media -Topic: Healthy relationships	Place ad on all media -Topic: Women's health	Place ad on all media -Topic: Child Abuse **-Radio 30-min**	Place ad on all media -Topic: Mental health in general

Monthly Reports

June 2021 Report

ESMERALDA OWEN PR

MCBH PSA MONTHLY REPORT

JUNE '21

ESMERALDAMONTENEGROOWEN@GMAIL.COM

213.220.1174

1114 VALBUSA DR. GILROY, CA 95020

DANA EDGULL, LCSW
BEHAVIORAL HEALTH SERVICES MANAGER II
MONTEREY COUNTY BEHAVIORAL HEALTH

I hope this finds you well. This is my first official report on PSA Project distribution and other activities to disseminate information in Spanish in Monterey County about mental health services.

For June, we launched the campaign with BRENDA talking about mental health services in general. The link to his PSA is: La Salud Mental: https://vimeo.com/554908227

The PSA was delivered to these TV and Radio stations:

-La Buena/La Ranchera Radios
-La Preciosa Radio
-Radio Bilingüe
-Comcast Spotlight
-KION/Telemundo/CW
-KSBW/ABC/Estrella TV
-Univision, UniMas, TriColor

These TV and Radio stations confirmed receipt of the PSA and added it to their PSA rotation for the month. They have committed space for the remainder of the campaign! Yay!

In addition, on June 9, 2021, a 30-minute radio show was recorded to be aired via La Buena and La Ranchera. This show was about the PSA campaign in general.

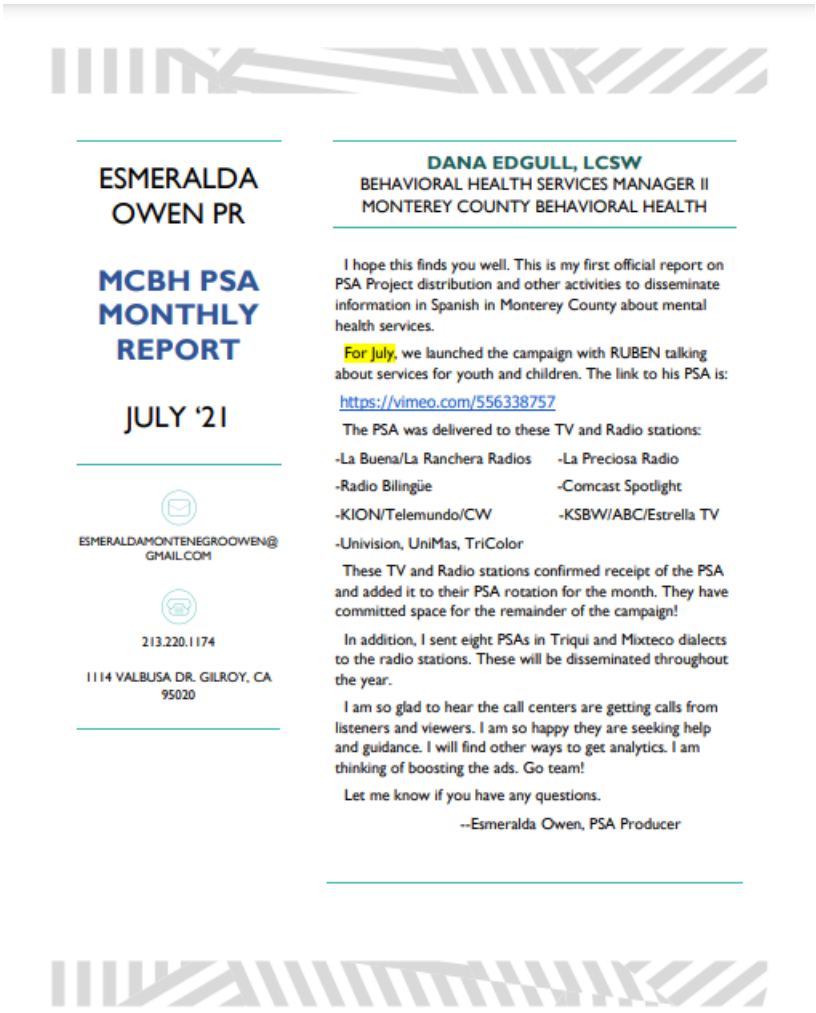
It is difficult to get analytics of TV and Radio spots, but I do know the Latino Community is listening.

The meeting we had in late June helped to finalize the 12 PSAs. I will be sending you all of those in the next days.

Let me know if you have any questions.

--Esmeralda Owen, PSA Producer

July 2021 Report



ESMERALDA OWEN PR

MCBH PSA MONTHLY REPORT

JULY '21

ESMERALDAMONTENEGROOWEN@GMAIL.COM

213.220.1174

1114 VALBUSA DR. GILROY, CA 95020

DANA EDGULL, LCSW
BEHAVIORAL HEALTH SERVICES MANAGER II
MONTEREY COUNTY BEHAVIORAL HEALTH

I hope this finds you well. This is my first official report on PSA Project distribution and other activities to disseminate information in Spanish in Monterey County about mental health services.

For July, we launched the campaign with RUBEN talking about services for youth and children. The link to his PSA is:

https://vimeo.com/556338757

The PSA was delivered to these TV and Radio stations:

-La Buena/La Ranchera Radios
-La Preciosa Radio
-Radio Bilingüe
-Comcast Spotlight
-KION/Telemundo/CW
-KSBW/ABC/Estrella TV
-Univision, UniMas, TriColor

These TV and Radio stations confirmed receipt of the PSA and added it to their PSA rotation for the month. They have committed space for the remainder of the campaign!

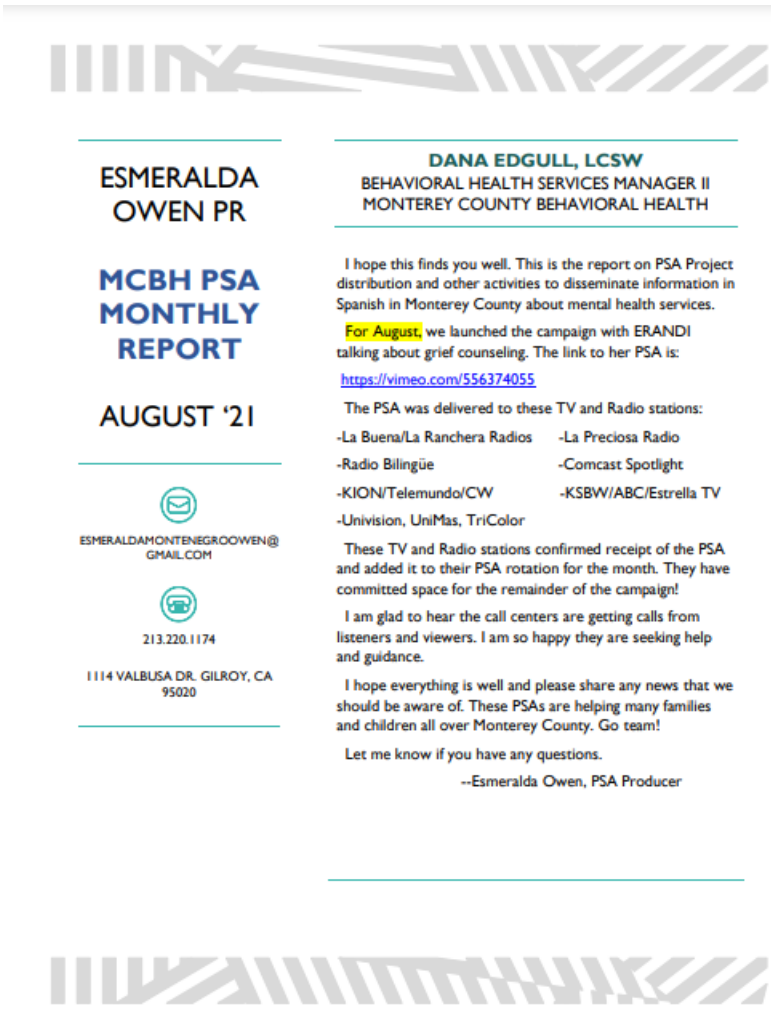
In addition, I sent eight PSAs in Triqui and Mixteco dialects to the radio stations. These will be disseminated throughout the year.

I am so glad to hear the call centers are getting calls from listeners and viewers. I am so happy they are seeking help and guidance. I will find other ways to get analytics. I am thinking of boosting the ads. Go team!

Let me know if you have any questions.

--Esmeralda Owen, PSA Producer

August 2021 Report



ESMERALDA OWEN PR

MCBH PSA MONTHLY REPORT

AUGUST '21

ESMERALDAMONTENEGROOWEN@GMAIL.COM

213.220.1174

1114 VALBUSA DR. GILROY, CA 95020

DANA EDGULL, LCSW
BEHAVIORAL HEALTH SERVICES MANAGER II
MONTEREY COUNTY BEHAVIORAL HEALTH

I hope this finds you well. This is the report on PSA Project distribution and other activities to disseminate information in Spanish in Monterey County about mental health services.

For August, we launched the campaign with ERANDI talking about grief counseling. The link to her PSA is:

https://vimeo.com/556374055

The PSA was delivered to these TV and Radio stations:

-La Buena/La Ranchera Radios
-La Preciosa Radio
-Radio Bilingüe
-Comcast Spotlight
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-Univision, UniMas, TriColor

These TV and Radio stations confirmed receipt of the PSA and added it to their PSA rotation for the month. They have committed space for the remainder of the campaign!

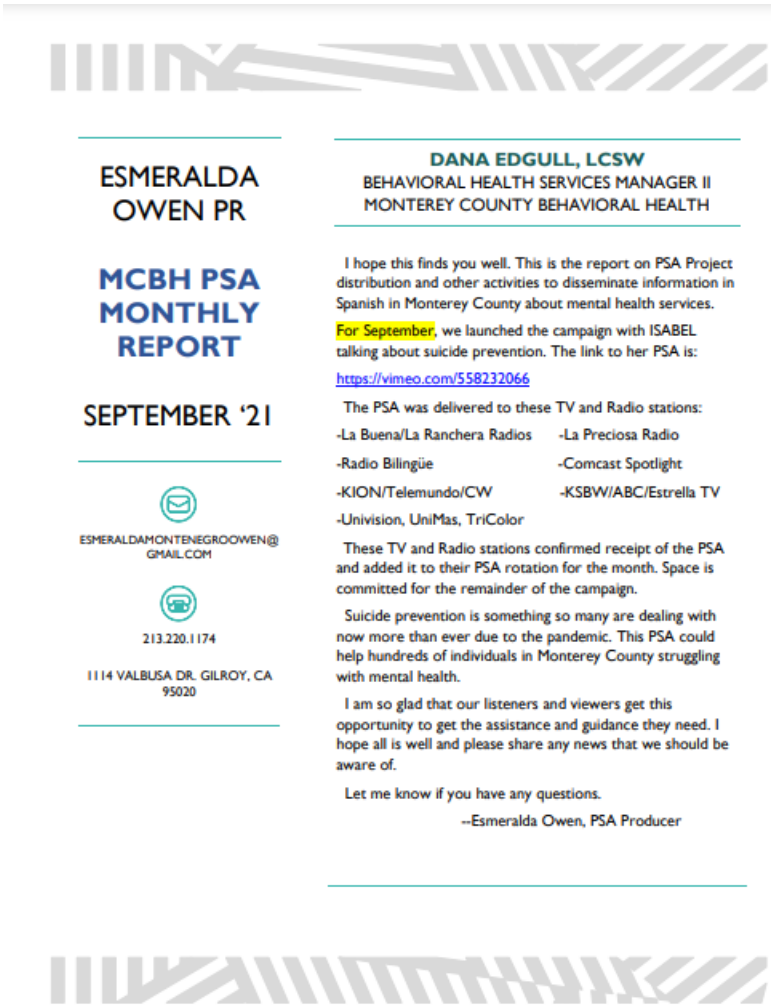
I am glad to hear the call centers are getting calls from listeners and viewers. I am so happy they are seeking help and guidance.

I hope everything is well and please share any news that we should be aware of. These PSAs are helping many families and children all over Monterey County. Go team!

Let me know if you have any questions.

--Esmeralda Owen, PSA Producer

September 2021 Report



ESMERALDA OWEN PR

MCBH PSA MONTHLY REPORT

SEPTEMBER '21

ESMERALDAMONTENEGROOWEN@GMAIL.COM

213.220.1174

1114 VALBUSA DR. GILROY, CA 95020

DANA EDGULL, LCSW
BEHAVIORAL HEALTH SERVICES MANAGER II
MONTEREY COUNTY BEHAVIORAL HEALTH

I hope this finds you well. This is the report on PSA Project distribution and other activities to disseminate information in Spanish in Monterey County about mental health services.

For September, we launched the campaign with ISABEL talking about suicide prevention. The link to her PSA is:

https://vimeo.com/558232066

The PSA was delivered to these TV and Radio stations:

-La Buena/La Ranchera Radios
-La Preciosa Radio
-Radio Bilingüe
-Comcast Spotlight
-KION/Telemundo/CW
-KSBW/ABC/Estrella TV
-Univision, UniMas, TriColor

These TV and Radio stations confirmed receipt of the PSA and added it to their PSA rotation for the month. Space is committed for the remainder of the campaign.

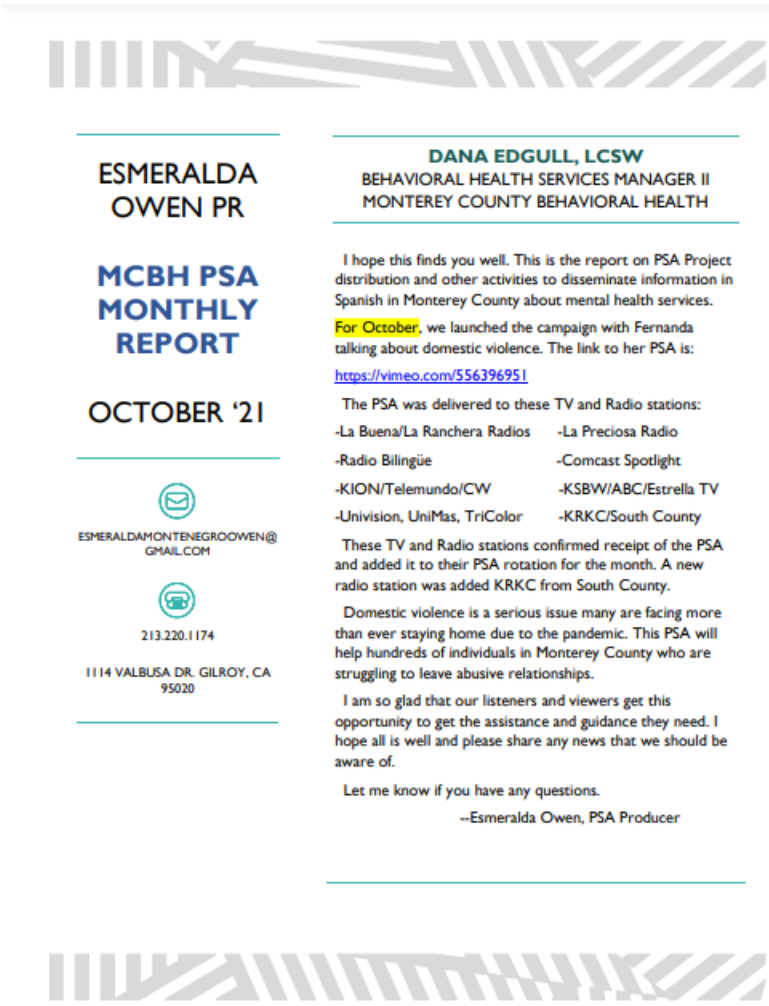
Suicide prevention is something so many are dealing with now more than ever due to the pandemic. This PSA could help hundreds of individuals in Monterey County struggling with mental health.

I am so glad that our listeners and viewers get this opportunity to get the assistance and guidance they need. I hope all is well and please share any news that we should be aware of.

Let me know if you have any questions.

--Esmeralda Owen, PSA Producer

October 2021 Report



ESMERALDA OWEN PR

MCBH PSA MONTHLY REPORT

OCTOBER '21

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213.220.1174

1114 VALBUSA DR. GILROY, CA 95020

DANA EDGULL, LCSW
BEHAVIORAL HEALTH SERVICES MANAGER II
MONTEREY COUNTY BEHAVIORAL HEALTH

I hope this finds you well. This is the report on PSA Project distribution and other activities to disseminate information in Spanish in Monterey County about mental health services.

For October, we launched the campaign with Fernanda talking about domestic violence. The link to her PSA is:

https://vimeo.com/556396951

The PSA was delivered to these TV and Radio stations:

-La Buena/La Ranchera Radios
-La Preciosa Radio
-Radio Bilingüe
-Comcast Spotlight
-KION/Telemundo/CW
-KSBW/ABC/Estrella TV
-Univision, UniMas, TriColor
-KRKC/South County

These TV and Radio stations confirmed receipt of the PSA and added it to their PSA rotation for the month. A new radio station was added KRKC from South County.

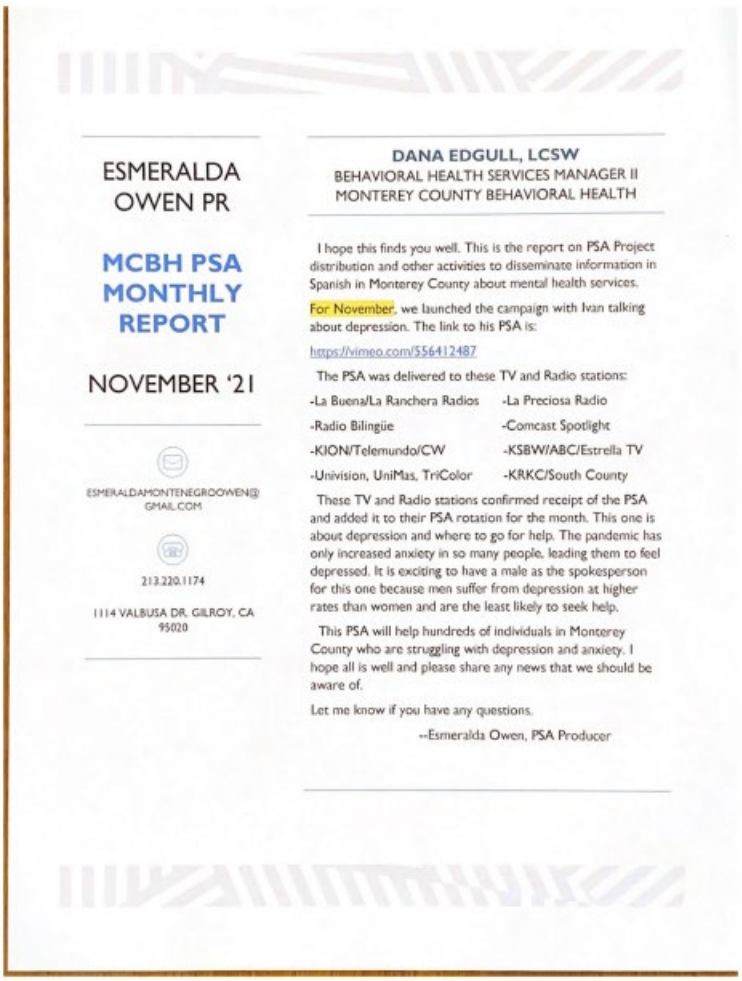
Domestic violence is a serious issue many are facing more than ever staying home due to the pandemic. This PSA will help hundreds of individuals in Monterey County who are struggling to leave abusive relationships.

I am so glad that our listeners and viewers get this opportunity to get the assistance and guidance they need. I hope all is well and please share any news that we should be aware of.

Let me know if you have any questions.

--Esmeralda Owen, PSA Producer

November 2021 Report



ESMERALDA OWEN PR

MCBH PSA MONTHLY REPORT

NOVEMBER '21

ESMERALDAMONTENEGROOWEN@GMAIL.COM

213.220.1174

1114 VALBUSA DR. GILROY, CA 95020

DANA EDGULL, LCSW
BEHAVIORAL HEALTH SERVICES MANAGER II
MONTEREY COUNTY BEHAVIORAL HEALTH

I hope this finds you well. This is the report on PSA Project distribution and other activities to disseminate information in Spanish in Monterey County about mental health services.

For November, we launched the campaign with Ivan talking about depression. The link to his PSA is:

https://vimeo.com/556412487

The PSA was delivered to these TV and Radio stations:

-La Buena/La Ranchera Radios
-La Preciosa Radio
-Radio Bilingüe
-Comcast Spotlight
-KION/Telemundo/CW
-KSBW/ABC/Estrella TV
-Univision, UniMas, TriColor
-KRKC/South County

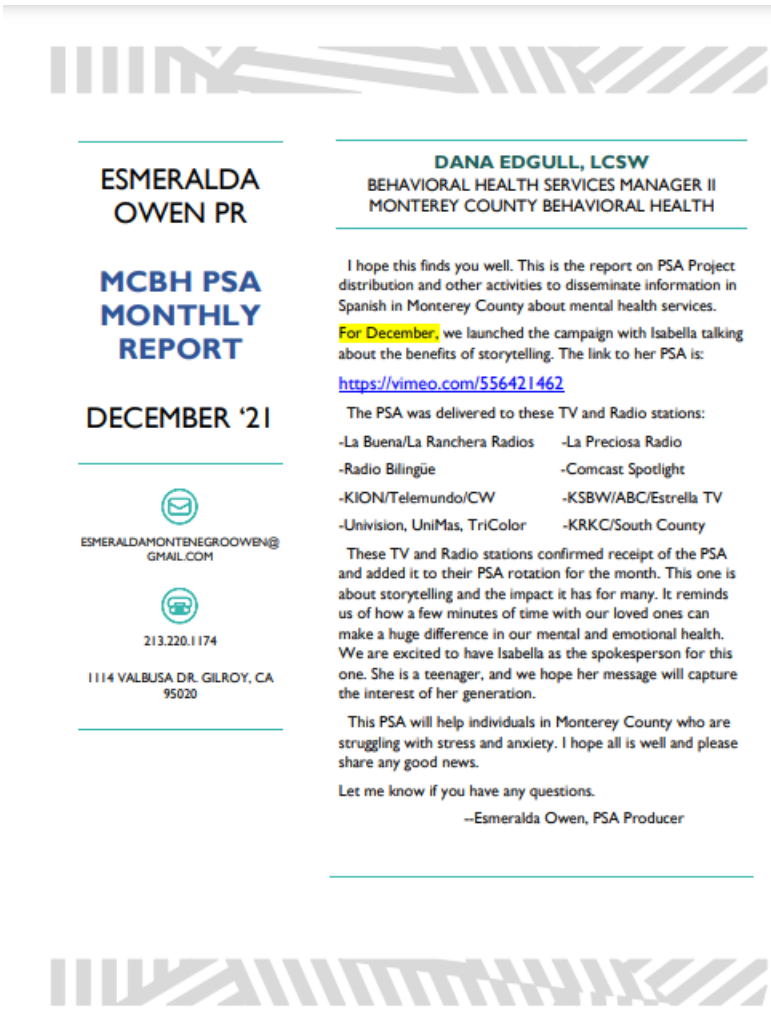
These TV and Radio stations confirmed receipt of the PSA and added it to their PSA rotation for the month. This one is about depression and where to go for help. The pandemic has only increased anxiety in so many people, leading them to feel depressed. It is exciting to have a male as the spokesperson for this one because men suffer from depression at higher rates than women and are the least likely to seek help.

This PSA will help hundreds of individuals in Monterey County who are struggling with depression and anxiety. I hope all is well and please share any news that we should be aware of.

Let me know if you have any questions.

--Esmeralda Owen, PSA Producer

December 2021 Report



ESMERALDA OWEN PR

MCBH PSA MONTHLY REPORT

DECEMBER '21

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213.220.1174

1114 VALBUSA DR. GILROY, CA 95020

DANA EDGULL, LCSW
BEHAVIORAL HEALTH SERVICES MANAGER II
MONTEREY COUNTY BEHAVIORAL HEALTH

I hope this finds you well. This is the report on PSA Project distribution and other activities to disseminate information in Spanish in Monterey County about mental health services.

For December, we launched the campaign with Isabella talking about the benefits of storytelling. The link to her PSA is:

https://vimeo.com/556421462

The PSA was delivered to these TV and Radio stations:

-La Buena/La Ranchera Radios
-La Preciosa Radio
-Radio Bilingüe
-Comcast Spotlight
-KION/Telemundo/CW
-KSBW/ABC/Estrella TV
-Univision, UniMas, TriColor
-KRKC/South County

These TV and Radio stations confirmed receipt of the PSA and added it to their PSA rotation for the month. This one is about storytelling and the impact it has for many. It reminds us of how a few minutes of time with our loved ones can make a huge difference in our mental and emotional health. We are excited to have Isabella as the spokesperson for this one. She is a teenager, and we hope her message will capture the interest of her generation.

This PSA will help individuals in Monterey County who are struggling with stress and anxiety. I hope all is well and please share any good news.

Let me know if you have any questions.

--Esmeralda Owen, PSA Producer

January 2022 Report

ESMERALDA OWEN PR

MCBH PSA MONTHLY REPORT

JANUARY '22

ESMERALDAMONTENEGROOWEN@GMAIL.COM

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1114 VALBUSA DR. GILROY, CA 95020

DANA EDGULL, LCSW
BEHAVIORAL HEALTH SERVICES MANAGER II
MONTEREY COUNTY BEHAVIORAL HEALTH

I hope this finds you well. This is the report on PSA Project distribution and other activities to disseminate information in Spanish in Monterey County about mental health services.

For January, we launched the campaign with Monica talking about postpartum depression. The link to her PSA is: https://vimeo.com/558292258

The PSA was delivered to these TV and Radio stations:

-La Buena/La Ranchera Radios	-La Preciosa Radio
-Radio Bilingüe	-Comcast Spotlight
-KION/Telemundo/CW	-KSBW/ABC/Estrella TV
-Univision, UniMas, TriColor	-KRKC/South County

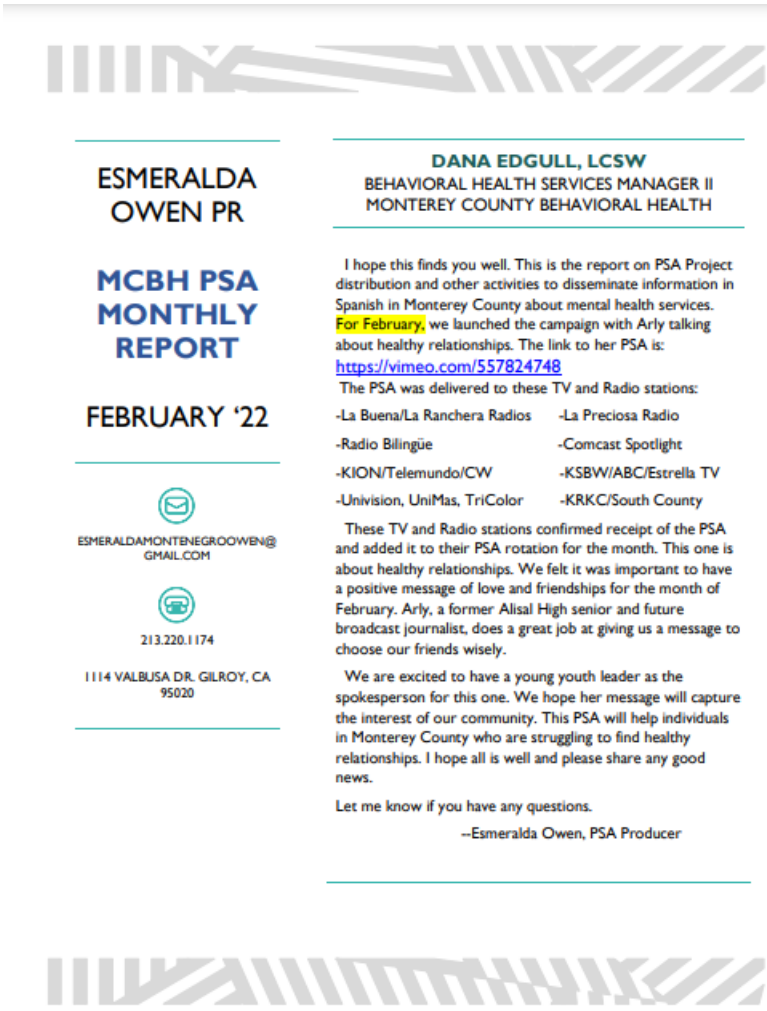
These TV and Radio stations confirmed receipt of the PSA and added it to their PSA rotation for the month. This one is about postpartum and the impact it has on women. It reminds us that it is normal to feel unwanted emotions for numerous first-time mothers and encourages women to seek help after giving birth. It will make a huge difference in their mental and emotional health. We are excited to have Monica as the spokesperson for this one. She is a mother, and we hope her message will capture the interest of our community.

This PSA will help individuals in Monterey County who are struggling with postpartum depression. I hope all is well and please share any good news.

Let me know if you have any questions.

--Esmeralda Owen, PSA Producer

February 2022 Report



ESMERALDA OWEN PR

MCBH PSA MONTHLY REPORT

FEBRUARY '22

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213.220.1174

1114 VALBUSA DR. GILROY, CA 95020

DANA EDGULL, LCSW
BEHAVIORAL HEALTH SERVICES MANAGER II
MONTEREY COUNTY BEHAVIORAL HEALTH

I hope this finds you well. This is the report on PSA Project distribution and other activities to disseminate information in Spanish in Monterey County about mental health services. For February, we launched the campaign with Arly talking about healthy relationships. The link to her PSA is: https://vimeo.com/557824748

The PSA was delivered to these TV and Radio stations:

-La Buena/La Ranchera Radios
-La Preciosa Radio
-Radio Bilingüe
-Comcast Spotlight
-KION/Telemundo/CW
-KSBW/ABC/Estrella TV
-Univision, UniMas, TriColor
-KRKC/South County

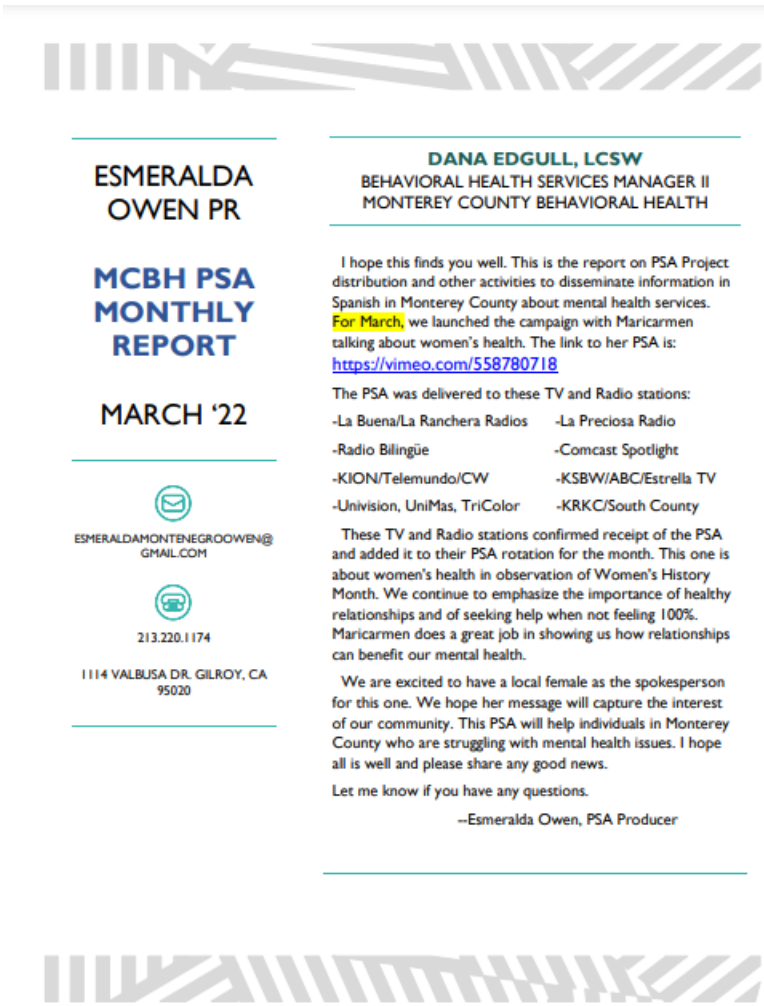
These TV and Radio stations confirmed receipt of the PSA and added it to their PSA rotation for the month. This one is about healthy relationships. We felt it was important to have a positive message of love and friendships for the month of February. Arly, a former Alisal High senior and future broadcast journalist, does a great job at giving us a message to choose our friends wisely.

We are excited to have a young youth leader as the spokesperson for this one. We hope her message will capture the interest of our community. This PSA will help individuals in Monterey County who are struggling to find healthy relationships. I hope all is well and please share any good news.

Let me know if you have any questions.

--Esmeralda Owen, PSA Producer

March 2022 Report



ESMERALDA OWEN PR

MCBH PSA MONTHLY REPORT

MARCH '22

ESMERALDAMONTENEGROOWEN@GMAIL.COM

213.220.1174

1114 VALBUSA DR. GILROY, CA 95020

DANA EDGULL, LCSW
BEHAVIORAL HEALTH SERVICES MANAGER II
MONTEREY COUNTY BEHAVIORAL HEALTH

I hope this finds you well. This is the report on PSA Project distribution and other activities to disseminate information in Spanish in Monterey County about mental health services. For March, we launched the campaign with Maricarmen talking about women's health. The link to her PSA is: https://vimeo.com/558780718

The PSA was delivered to these TV and Radio stations:

-La Buena/La Ranchera Radios
-La Preciosa Radio
-Radio Bilingüe
-Comcast Spotlight
-KION/Telemundo/CW
-KSBW/ABC/Estrella TV
-Univision, UniMas, TriColor
-KRKC/South County

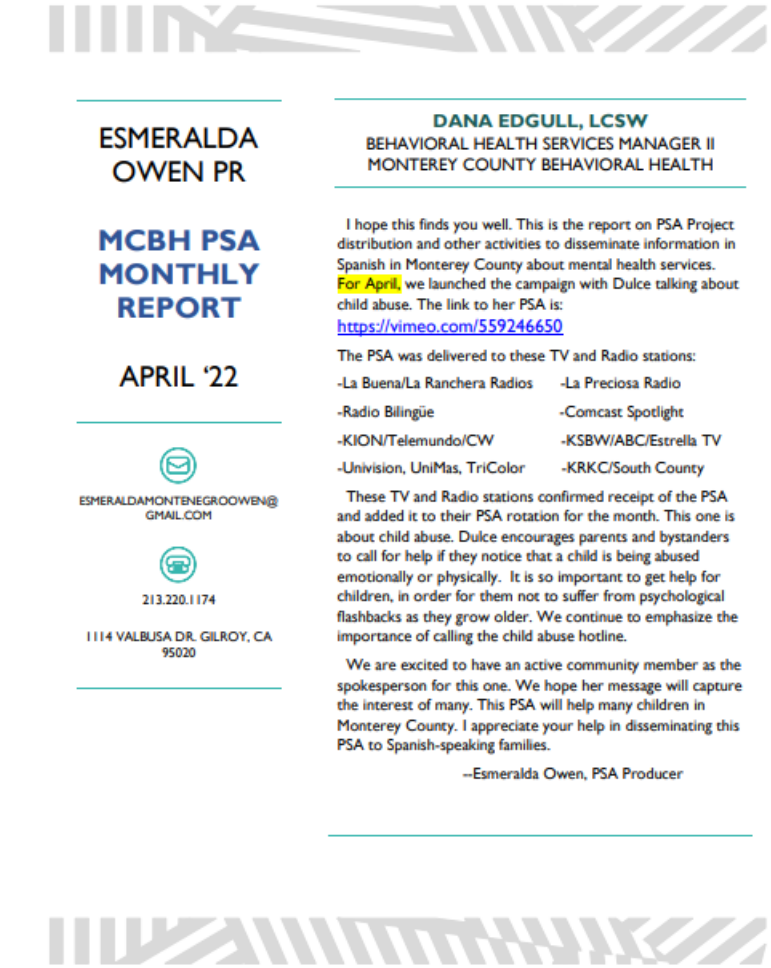
These TV and Radio stations confirmed receipt of the PSA and added it to their PSA rotation for the month. This one is about women's health in observation of Women's History Month. We continue to emphasize the importance of healthy relationships and of seeking help when not feeling 100%. Maricarmen does a great job in showing us how relationships can benefit our mental health.

We are excited to have a local female as the spokesperson for this one. We hope her message will capture the interest of our community. This PSA will help individuals in Monterey County who are struggling with mental health issues. I hope all is well and please share any good news.

Let me know if you have any questions.

--Esmeralda Owen, PSA Producer

April 2022 Report



ESMERALDA OWEN PR

MCBH PSA MONTHLY REPORT

APRIL '22

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213.220.1174

1114 VALBUSA DR. GILROY, CA 95020

DANA EDGULL, LCSW
BEHAVIORAL HEALTH SERVICES MANAGER II
MONTEREY COUNTY BEHAVIORAL HEALTH

I hope this finds you well. This is the report on PSA Project distribution and other activities to disseminate information in Spanish in Monterey County about mental health services. For April, we launched the campaign with Dulce talking about child abuse. The link to her PSA is:
https://vimeo.com/559246650

The PSA was delivered to these TV and Radio stations:

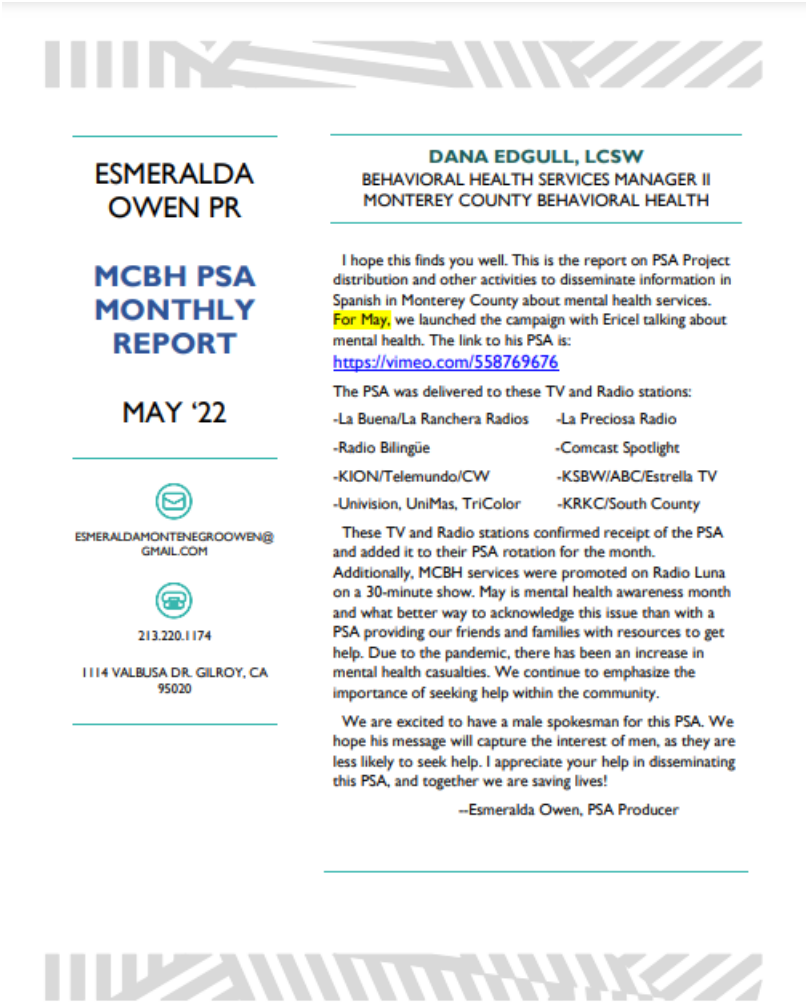
-La Buena/La Ranchera Radios	-La Preciosa Radio
-Radio Bilingüe	-Comcast Spotlight
-KION/Telemundo/CW	-KSBW/ABC/Estrella TV
-Univision, UniMas, TriColor	-KRKC/South County

These TV and Radio stations confirmed receipt of the PSA and added it to their PSA rotation for the month. This one is about child abuse. Dulce encourages parents and bystanders to call for help if they notice that a child is being abused emotionally or physically. It is so important to get help for children, in order for them not to suffer from psychological flashbacks as they grow older. We continue to emphasize the importance of calling the child abuse hotline.

We are excited to have an active community member as the spokesperson for this one. We hope her message will capture the interest of many. This PSA will help many children in Monterey County. I appreciate your help in disseminating this PSA to Spanish-speaking families.

--Esmeralda Owen, PSA Producer

May 2022 Report



ESMERALDA OWEN PR

MCBH PSA MONTHLY REPORT

MAY '22

ESMERALDAMONTENEGROOWEN@GMAIL.COM

213.220.1174

1114 VALBUSA DR. GILROY, CA 95020

DANA EDGULL, LCSW
BEHAVIORAL HEALTH SERVICES MANAGER II
MONTEREY COUNTY BEHAVIORAL HEALTH

I hope this finds you well. This is the report on PSA Project distribution and other activities to disseminate information in Spanish in Monterey County about mental health services. For May, we launched the campaign with Ericel talking about mental health. The link to his PSA is:
https://vimeo.com/558769676

The PSA was delivered to these TV and Radio stations:

-La Buena/La Ranchera Radios
-La Preciosa Radio
-Radio Bilingüe
-Comcast Spotlight
-KION/Telemundo/CW
-KSBW/ABC/Estrella TV
-Univision, UniMas, TriColor
-KRKC/South County

These TV and Radio stations confirmed receipt of the PSA and added it to their PSA rotation for the month. Additionally, MCBH services were promoted on Radio Luna on a 30-minute show. May is mental health awareness month and what better way to acknowledge this issue than with a PSA providing our friends and families with resources to get help. Due to the pandemic, there has been an increase in mental health casualties. We continue to emphasize the importance of seeking help within the community.

We are excited to have a male spokesman for this PSA. We hope his message will capture the interest of men, as they are less likely to seek help. I appreciate your help in disseminating this PSA, and together we are saving lives!

--Esmeralda Owen, PSA Producer

Round 5

Monterey County Public Health Bureau

"POSTPONE PROGRAM ADAPTATION"

FOR INCLUSION OF
BEHAVIORAL HEALTH SERVICES EDUCATION AND REFERRAL SERVICES

August 1, 2021 to June 30, 2022


MONTEREY COUNTY CALIFORNIA
1850

Contents

Project Summary

Monterey County Health Department's Postpone Program served schools in the Salinas Union High School District (SUHSD) and North Monterey County Middle School by providing training, education, and resources in the areas of mental health and teen pregnancy prevention services. This micro innovation project was completed through Postpone (a teen pregnancy prevention program) that has been implemented in our community for over 25 years. All incoming freshmen at Alisal High School, and students taking health education at Everett Alvarez High School, were served by way of peer education and fotonovela (a storytelling tool to engage youth in learning about issues such as health and other adult preparation topics).

This micro innovation project was proposed to bridge an information gap. Prior to the micro innovation project youth received information and education related to their physical development, sexual and reproductive health, and other adult preparation areas. However, Postpone had not addressed youth mental health needs or provided mental health resources. Postpone facilitators had noted that trauma, depression, and anxiety seemed to be among the mental health issues commonly observed in program participants and these were occasionally disclosed to the facilitators by the students themselves.

Postpone staff proposed to expand the program to address youth mental health needs by providing mental health education directly to youth and by making and tracking referrals to Behavioral Health. The goal was to train a minimum total of 30 high school students at Alisal and Everett Alvarez High Schools and one college level student intern to serve as peer educators through implementation of the Mind Matters curriculum. A second goal was to reach a total of 1,030 students from Alisal and Everett Alvarez through classroom presentations. Postpone peer educators completed one-on-one outreach to their peers, documented their interactions, and posted to their personal social media accounts including Instagram and Snapchat positive messages about accessing mental health services, tips on mental health, and mental health resources. Posts were intended to reduce stigma and increase the understanding of mental health resources and services.

In the city of Salinas, where both Alisal and Everett Alvarez High Schools are located, a Latinx family is three times more likely to live below the poverty level compared to a White, non-Hispanic family (2019 ACS, 1-Year Estimates US Census Bureau). The Centers for Disease Control and Prevention noted in a 2016 report (Vaughn, M.G., Salas-Wright, C.P. & Maynard, B.R. J Public Health (2014) 22: 265) that one important strategy to prevent and reduce health disparities is increased education in general, including high school completion. This proposal aligned with this strategy to support reducing health disparities and addressed some of the barriers to high school completion, such as teen pregnancy and unmet mental health needs. This project was built on the success of the Postpone program in reaching and engaging youth to provide outreach, information, and referrals for youth.

Many young people who need mental health treatment do not receive it. Research suggests that adolescents are more likely to modify their behaviors and attitudes if they receive health messages from peers who face similar concerns and pressures, Fatemeh Abdi, (2013) The Peer Education Approach in Adolescents. Teens often go to other teens to get help for things such as reproductive health, homework, employment, etc. The Postpone program used a peer education

model and students received accurate information and resources from their peers. Postpone peer educators were assigned to classrooms to speak on topics such as depression, anxiety, and mental health to normalize discussing mental health services and to increase the likelihood that the youth in the classrooms will seek mental health services.

The Postpone program purchased from The Dibble Institute the evidence-based Mind Matters curriculum and training. Mind Matters was implemented to help youth overcome adversity and build resilience. Mind Matters has been used by other agencies to prevent violence, address chronic absenteeism, and build a culture of wellness. Mind Matters lessons addressed the following topics:

- Self-Soothing and Regulating Emotions: Cultivating a mindfulness practice
- Managing Stress Effectively: Learning to reduce intrusive thoughts
- Developing Empathy: Improving interpersonal communications
- Creating a Code of Honor: Developing a life of intention
- Building and Using a Support System: Learning how to ask for help

Postpone peer educators and college interns were trained in the Mind Matters curriculum. Through peer educator presentations and other interactions high school students were given tools to seek help and address some of the mental health issues they might be experiencing. Postpone peer educators and a student intern, under the guidance of a public health coordinator, were a natural fit to learn this curriculum and apply the learned skills to their outreach and presentations. The skills taught in Mind Matters were designed to be practiced over a lifetime. The curriculum did not replace therapy.

Peer Educators

Postpone trained and recruited high school students in Salinas from both Alisal and Everett Alvarez High Schools, ages 13-18, to be part of the peer education program. Peer educators learned the standard Postpone topics in adult preparation, sexual and reproductive health, and additionally through this project they learned to promote mental health and access to services. The initial goal was to train a minimum of 15 Postpone peer educators at each of the high schools (a minimum total of 30 peer educators). Postpone exceeded this goal.

During the 2021-2022 school year Postpone trained 65 peer educators. 59 peer educators were from Alisal High School and 6 were from Everett Alvarez High School. The Alisal High School site had the benefit of a very involved teacher as the Postpone advisor. Additional activities and incentives were possible with the involvement of a supportive teacher. While Everett Alvarez High School also designated a teacher, the assigned teacher had limited availability to dedicate to the project.

Every effort was made for peer educators to complete 100% of the training and when completion was not possible, due to unplanned circumstances, the peer educators were required to complete at least 75% of the training to continue as peer educators. 59 peer educators completed 100% of the peer educator training and only 6 students completed less than 75% of the training.

Most schools served were in the Salinas Union High School District (SUHSD). SUHSD consists of five high schools, four middle schools, one independent study school, one alternative high school, Regional Occupational Program Center, and an Adult School. In 2021-2022 district enrollment was 16,525 students with 84% unduplicated count of the students qualifying for Free and Reduced Lunch, English Learners, and Foster Youth. Schools within the SUHSD have interventions during the school day, inter-sessions, and on Saturdays to provide support to students as needed.

Peer Educator Engagements with Students

The schools' students were the proposed focus population and included a significant number of students who are facing language barriers in accessing County services. According to Ed-data.org in 2021-2022, approximately 21% of students at Alisal High School and 18% at Everett Alvarez, were English learners. Both schools serve speakers of languages beyond Spanish, such as Tagalog, Korean, and many indigenous languages including Triqui, Mixtec, Zapotec, and Nahuatl.

<u>2021-2022 student enrollment in the schools served:</u>

- Alisal High School 3,008 students
    - Total minority enrollment is 99%
    - 94% of students are economically disadvantaged
- Everett Alvarez High School 2,113 students
    - Total minority enrollment is 97%
    - 89% of students are economically disadvantaged

- North Monterey County Middle School 679 students
    - Total minority enrollment is 93%
    - 83% of students are economically disadvantaged.
- Rancho San Juan High School 1,249 students
    - Total minority enrollment is 93%
    - 84% of students are economically disadvantaged

Upon completion of the Mind Matters curriculum, peer educators adapted program material to include behavioral health information to fellow students via in person presentations and other in person contacts as well as through their personal social media accounts. Peer educators also made themselves available to students one on one. In addition to adding information on mental health services to their presentations, the Postpone program included information on flyers and posted information in the classrooms. All students who are present during peer educator presentations received a resource sheet of existing mental health services available in our county. Each student that attended the Postpone presentations received information about how to make clinical mental health appointments. Under the direction of the Health Program Coordinator, the program interns made weekly calls to students to see if the students attended at least one of their Behavioral Health appointments.

Peer educators presented and promoted program material to students which included behavioral health messages and resources to all freshmen at Alisal High School during the Advancement Via Individual Determination (AVID) program. The AVID program is a nationally recognized program that prepares students for four-year college eligibility. Peer educators also presented at

health classes at Everett Alvarez High School. When presenting at Everett Alvarez High School was not possible due to the school's limited staff resources, presentations were completed at North Monterey County Middle School and at Rancho San Juan High School.

Each peer educator completed at least one social media post. During the project term at least 65 posts were created. Posts were made by peer educators directly to their personal social media accounts including Instagram and Snapchat. Posts included positive messages about accessing mental health services, tips on mental health, and mental health resources. Posts were intended to reduce stigma and increase the understanding of mental health resources and services. Social media analytics such as "likes, comments, share and saves" were not possible to track during the project due to students posting on their own social media platforms as stories rather than as reels on the Postpone program account.

While stories and snapchats remained for short periods of time and then were automatically deleted, the advantage to posting information in this manner was that the stories and snapchats were seen by more youth than if the post had been limited to those following the program feed as originally planned. Upon further assessment of the program account followers, it was determined the followers to this account would not meet the project goals and the decision was made to encourage youth to post on personal accounts. Based on empirical data from our student interns and peer educators, content associated with high-engagement social media posts were those posts which provided an interactive yet somewhat "anonymous" way to ask questions and share experiences and posts which reassured youth that they are not alone in feeling depressed, anxious, stressed, etc.

The initial goal was for peer educators to reach an unduplicated 1,030 youth through Postpone. Through classroom presentations alone this goal was exceeded. 77 presentations were completed and through these presentations peer educators reached 1,740 unduplicated youth through Postpone. Another 1,000 youth were reached through Making Proud Choices (MPC). MPC is another teen pregnancy program offered by Public Health. Had social media analytics been available, the reported number of students reached would have been even higher.

Behavioral Health Service Referrals

The goal was to refer into services 10% of youth reached (103 youth based on the original goal). Tracking the number of youths referred into services was challenging and Postpone was unable to accurately track this number. Among the challenges experienced were requests from students declining to state either verbally or through survey whether they had called the Behavioral Health telephone number (888-258-6029), spoken to Behavioral Health staff, or attended an appointment. Students stated they preferred to keep this confidential, including keeping this confidential from their peer educators. Peer educators reported another challenge, several students indicated they were more comfortable seeking services at the school (e.g., school wellness center) rather than calling a Behavioral Health clinic because they didn't know who would be on the other end of the telephone line and feared they would be judged. A third challenge in tracking was the Postpone program's unexpected change in staff, including retirement of the Project Director. Reduced staffing impacted the program's ability to further troubleshoot tracking of referrals.

Each student was assigned a unique participant number. Program staff had initially planned that these numbers could assist in tracking and reporting out how many youths had been referred, sought, and received services. However, without the students' willingness to disclose to Behavioral Health their unique participant number, that they were being referred by Postpone Peer Educators, reporting to peer educators that they called the intake number, or visited the wellness center, a direct correlation to our outreach efforts was not possible.

Postpone program is open to troubleshooting solutions for tracking should a future project be proposed. At this time, Postpone is only able to accurately track only the number of youths reached through presentations. 1,740 youth participating in presentations were provided with information on accessing Behavioral Health Services.

Peer educators assisted the Chronic Disease Prevention Coordinator with follow ups. Follow ups were completed in group and/or one-on-one. During the follow ups completed by peer educators, the peer educators had 20 students voluntarily disclose that they sought mental health services at school or following a Postpone presentation. It is unknown how many of the 20 students sought services at school and how many sought services through Behavioral Health, this information was not disclosed to peer educators.

Description Of Successes, Challenges And Barriers

Successes associated with this project included initiating conversations and sharing information with youth about mental health and seeking mental health services. Postpone provided a safe space for youth to hear about and normalize the topic of mental health. Some youth shared their own experiences, and this reminded other students that mental health issues are common, and that support is available.

Peer Educators stated they really liked the Mind Matters content. The information they learned was shared with others via social media posts, and during one-on-one conversations with students. Peer educators also reported that they were using the information learned to help their siblings and friends. Peer educators learned to identify some of the signs, such as declines in school performance, poor grades, constant anxiety, social withdrawal, or aggression, which may indicate the need for mental health services. The Mind Matters curriculum assisted not just our Postpone peer educators but also facilitators and students across all our teen pregnancy prevention programs to clear away barriers to their own focus and learning and helped to build skills in the educators that transferred to others through one-on-one interactions.

If this program were regularly offered through Postpone it could contribute towards improved perceptions of mental health services and promote greater help-seeking behavior among our youth. If the program were to be offered again, challenges and barriers associated with this project must be addressed. These include developing a tracking system for: the number of youths referred, number of youths who called Behavioral Health, number of youths who sought services through other resources such as school counselors or wellness centers, and calls which were a direct result of information shared through Postpone peer educators.

Youth requested that future projects have an anonymous way to track referrals because seeking mental health services is not something they want to openly share. Youth stated they feared stigma with accessing mental health services and stated they felt embarrassed or ashamed. Youth

were unwilling to share whether they had called Behavioral Health or accessed services. Postpone Peer Educators encountered a resistance from students in sharing this information in groups and individually through follow ups.

During follow ups and debriefs some youth reported hearing from other youth of "bad service" when calling the Behavioral Health referral number. No additional detail was provided on this. Due to the context of the discussion, the program believes this information could have stemmed from the students' being asked for identifying information by the person answering the Behavioral Health phone. In other words, students may have felt discouraged to seek help by having to provide their identifying information. Other students reported that they received the help they needed when calling the Behavioral Health number, yet it was unclear when they had called and if services were sought during the project timeline.

Students reported being confused about the referral and intake process, not understanding whether they should call back or if someone was going to call them back. Some students who shared information with peer educators stated intake forms were challenging to complete. Lastly, youth reported concerns with some school procedures requiring students to first obtain a referral from their school's academic counselor prior to seeking mental health services through the school's wellness center.

Recommendations

Anonymity and confidentiality around referrals and appointments was critically important to the youth in this project. Youth did not wish to share, even with the peer educators who they had built relationships with, any information about accessing Behavioral Health services. Students recommended implementation of services which would allow youth to access care and support anonymously if possible. Postpone staff found that students were concerned about the confidentiality of their information/record. Similar to the concerns students have when staff make referrals to Family Pact clinics for medical appointments. Students are concerned about who will have access to their record, specifically if a parent will be able to access their record. More education and information services are needed by students on the right to privacy when seeking Behavioral Health services.

From this project Postpone staff learned that to become more responsive for this population there must be a more instant way to refer students directly to an on-call professional. Youth recommended a referral number that is dedicated to teens and can be accessed via text (the benefit they reported would be receiving immediate support and "wouldn't be as scary as calling and talking to someone"). While crisis text lines are available to youth through national and state resources, staff and peer educators were unaware of local text options for youth who are seeking ongoing mental health support in a non-crisis situation. A local text option for teens is highly recommended.

Lastly, students shared concerns and confusion over school procedures/policies regarding how to access Behavioral Health or counseling services. Students shared that different schools seem to have different procedures. Students expressed concern over "extra and unnecessary hurdles" such as at one school a requirement to see their school counselor before being "allowed" to go to the wellness clinic or other mental health support person. Increased information to students and schools is recommended on the role of a school guidance counselor in the high schools and their

role in making referrals to Behavioral Health.

Acknowledgement

Postpone gratefully acknowledges Monterey County Behavioral Health Micro Innovation Grant 2021-2022 for funding adaptations to the Postpone Program to support local students in learning about and accessing behavioral health services.

Students reached at Alisal High School 2021-2022

Alisal High School																											
	AHS_10/27/2021_PatelPer1	AHS_10/27/2021_PatelPer2	AHS_10/27/2021_PatelPer3	AHS_10/27/2021_PatelPer4	AHS_10/27/2021_PatelPer5	AHS_10/27/2021_PatelPer6	AHS_03/23/22_MadrigalPer1	AHS_03/23/22_MadrigalPer2	AHS_03/23/22_MadrigalPer3	AHS_03/23/22_MadrigalPer4	AHS_03/23/22_MadrigalPer5	AHS_03/23/22_MadrigalPer6	AHS_03/25/22_BundenPer1	AHS_03/25/22_BundenPer2	AHS_03/25/22_BundenPer3	AHS_03/25/22_BundenPer5	AHS_03/25/22_BundenPer6	AHS_03/23/22_GrantPer2	AHS_03/23/22_GrantPer3	AHS_03/23/22_GrantPer4	AHS_03/23/22_GrantPer5	AHS_03/23/22_GrantPer6					Total Percentage
Gender																											
Female	17	10	12	15	17	10	11	11	18	16	12	15	21	15	11	13	9	13	11	8	10	16				291	50%
Male	10	12	16	13	12	19	11	17	12	12	11	12	8	12	16	12	14	11	18	17	15	9				289	50%
NA	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0				0	0%
Gender Total	27	22	28	28	29	29	22	28	30	28	23	27	29	27	27	25	23	24	29	25	25	25	0	0	0	580	100%
Age																											
11	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0				0	0%
12	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0				0	0%
13	1	1	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0				4	1%
14	25	19	26	25	27	27	12	23	21	15	12	17	16	12	18	12	13	12	15	13	19	14				393	68%
15	1	2	2	1	2	2	10	5	9	13	11	10	13	15	9	13	10	12	14	12	6	11				183	32%
16	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0				0	0%
17	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0				0	0%
18	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0				0	0%
19	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0				0	0%
NA	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0				0	0%
Age Total	27	22	28	28	29	29	22	28	30	28	23	27	29	27	27	25	23	24	29	25	25	25	0	0	0	580	100%
Ethnicity																											
Latino	25	21	28	28	27	27	22	25	28	28	23	27	28	27	27	25	21	23	29	25	25	25				564	97%
White	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	0	0	0	0				2	0%
African	0	0	0	0	0	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0				2	0%
Amer Indian	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0				0	0%
Pacific Islander	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0				1	0%
Asian	2	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0				5	1%
Other	0	1	0	0	0	2	0	2	0	0	0	0	1	0	0	0	0	0	0	0	0	0				6	1%
Blank	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0				0	0%
Ethnicity Total	27	22	28	28	29	29	22	28	30	28	23	27	29	27	27	25	23	24	29	25	25	25	0	0	0	580	100%

22 presentations, 580 students

Alisal High School																																								
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36		
	AHS_04/05/2022_PatelPer1	AHS_04/05/2022_PatelPer2	AHS_04/05/2022_PatelPer3	AHS_04/05/2022_PatelPer4	AHS_04/05/2022_PatelPer5	AHS_04/05/2022_PatelPer6	AHS_04/07/22_BundenPer1	AHS_04/07/22_BundenPer2	AHS_04/07/22_BundenPer3	AHS_04/07/22_BundenPer5	AHS_04/07/22_BundenPer6	AHS_04/26/22_GrantPer2	AHS_04/26/22_GrantPer3	AHS_04/26/22_GrantPer4	AHS_04/26/22_GrantPer5	AHS_04/26/22_GrantPer6	AHS_04/27/22_MadrigalPer1	AHS_04/27/22_MadrigalPer2	AHS_04/27/22_MadrigalPer3	AHS_04/27/22_MadrigalPer4	AHS_04/27/22_MadrigalPer5	AHS_04/27/22_MadrigalPer6																	Total Percentage
Gender																																								
Female	18	11	11	16	17	10	23	18	12	13	11	11	10	6	11	9	14	10	18	16	14	15															294	
Male	14	12	15	12	11	17	8	13	18	12	14	13	18	15	12	10	9	16	9	11	10	12															281	49%
NA	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0															0	0%
Gender Total	32	23	26	28	28	27	31	31	30	25	25	24	28	21	23	19	23	26	27	27	24	27	0	0	0	0	0	0	0	0	0	0	0	0	0	0	575	49%
Age																																								
11	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0															0	0%
12	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0															0	0%
13	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0															0	0%
14	20	13	11	16	18	15	17	14	17	11	12	10	13	9	15	7	9	18	13	13	12	16															299	52%
15	12	10	15	12	10	12	14	17	13	14	13	14	15	12	8	12	14	8	14	14	12	11															276	48%
16	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0															0	0%
17	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0															0	0%
18	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0															0	0%
19	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0															0	0%
NA	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0															0	0%
Age Total	32	23	26	28	28	27	31	31	30	25	25	24	28	21	23	19	23	26	27	27	24	27	0	0	0	0	0	0	0	0	0	0	0	0	0	0	575	100%
Ethnicity																																								
African A	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0															1	0%
Latino/His	31	23	26	28	25	25	31	30	30	25	20	23	28	21	23	19	23	25	23	27	23	27															556	97%
White	0	0	0	0	0	0	0	0	0	0	5	0	0	0	0	0	0	0	2	0	0	0															7	1%
American I	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0															0	0%
Pacific Is	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0															1	0%
Asian	1	0	0	0	2	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0															4	1%
Other	0	0	0	0	1	2	0	0	0	0	0	1	0	0	0	0	0	1	0	0	1	0															6	1%
NA	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0															0	0%
Ethnicity Total	32	23	26	28	28	27	31	31	30	25	25	24	28	21	23	19	23	26	27	27	24	27	0	0	0	0	0	0	0	0	0	0	0	0	0	0	575	100%

22 presentations, 575 students

Students reached at North Monterey County Middle School and Rancho San Juan 2022

North Monterey County Middle School and Rancho San Juan																								
NMCMS_03/09/2022_SantanaPer1	NMCMS_03/09/2022_SantanaPer2	NMCMS_03/09/2022_SantanaPer4	NMCMS_03/09/2022_SantanaPer6	NMCMS_03/16/2022_SantanaPer1	NMCMS_03/16/2022_SantanaPer2	NMCMS_03/16/2022_SantanaPer4	NMCMS_03/16/2022_SantanaPer6	NMCMS_05/18/2022_SantanaPer2	NMCMS_05/18/2022_SantanaPer3	NMCMS_05/18/2022_SantanaPer4	NMCMS_05/18/2022_SantanaPer6	NMCMS_05/25/2022_SantanaPer2	NMCMS_05/25/2022_SantanaPer3	NMCMS_05/25/2022_SantanaPer4	NMCMS_05/25/2022_SantanaPer6	RSJHS_03/22/2022_JohnsonPer2	RSJHS_03/22/2022_JohnsonPer4							Total Percentage
10	12	12	5	6	15	9	9	11	4	9	5	8	6	7	7	5	3						143	46%
5	9	15	12	10	6	8	7	8	11	11	9	8	11	10	11	9	6						166	54%
1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0						1	0%
16	21	27	17	16	21	17	16	19	15	20	14	16	17	17	18	14	9	0	0	0	0	0	310	100%
0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0						0	0%
8	0	8	0	8	8	0	0	0	0	0	0	0	0	0	0	0	0						32	10%
7	15	15	9	8	13	12	7	6	6	8	10	5	9	4	8	0	0						142	46%
0	6	4	7	0	0	5	9	13	9	12	4	11	8	13	10	2	0						113	36%
0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	2	1						4	1%
0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	6	5						11	4%
0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	1						3	1%
0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0						0	0%
0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0						1	0%
1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	2						4	1%
16	21	27	17	16	21	17	16	19	15	20	14	16	17	17	18	14	9	0	0	0	0	0	310	100%
12	8	26	15	15	19	16	14	17	14	19	13	16	12	17	16	12	6						267	86%
2	0	1	0	1	0	0	2	2	1	1	1	0	4	0	1	0	0						16	5%
0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0						0	0%
0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0						1	0%
0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0						0	0%
0	0	0	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0						2	1%
0	3	0	1	0	2	1	0	0	0	0	0	0	0	0	0	0	0						7	2%
2	10	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	3						17	5%
16	21	27	17	16	21	17	16	19	15	20	14	16	17	17	18	14	9	0	0	0	0	0	310	100%

16 presentations at NMCMS, 287 students 2 presentations at Rancho San Juan, 23 students

North Monterey County Middle School

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21		
NMCMS_03/10/2022_SantanaPer1	NMCMS_03/10/2022_SantanaPer2	NMCMS_03/10/2022_SantanaPer4	NMCMS_03/10/2022_SantanaPer6	NMCMS_03/17/2022_SantanaPer1	NMCMS_03/17/2022_SantanaPer2	NMCMS_03/17/2022_SantanaPer4	NMCMS_03/17/2022_SantanaPer6	NMCMS_05/19/2022_SantanaPer2	NMCMS_05/19/2022_SantanaPer3	NMCMS_05/19/2022_SantanaPer4	NMCMS_05/19/2022_SantanaPer6	NMCMS_05/26/2022_SantanaPer3	NMCMS_05/26/2022_SantanaPer4	NMCMS_05/26/2022_SantanaPer6								Total Percentage
11	11	8	5	7	12	14	10	11	5	8	7	6	8	7							130	47%
4	10	14	12	10	6	8	7	8	12	11	9	10	10	13							144	52%
0	0	0	1	0	0	0	0	0	0	0	0	0	0	0							1	0%
15	21	22	18	17	18	22	17	19	17	19	16	16	18	20	0	0	0	0	0	0	275	100%
Age																						
0	0	0	0	0	0	0	0	0	0	0	0	0	0	0							0	0%
9	0	8	0	8	8	0	0	0	0	0	0	0	0	0							33	12%
6	16	11	10	9	10	17	7	7	6	7	10	10	4	9							139	51%
0	5	3	6	0	0	5	10	12	11	12	6	6	14	11							101	37%
0	0	0	1	0	0	0	0	0	0	0	0	0	0	0							1	0%
0	0	0	0	0	0	0	0	0	0	0	0	0	0	0							0	0%
0	0	0	0	0	0	0	0	0	0	0	0	0	0	0							0	0%
0	0	0	0	0	0	0	0	0	0	0	0	0	0	0							0	0%
0	0	0	0	0	0	0	0	0	0	0	0	0	0	0							0	0%
0	0	0	1	0	0	0	0	0	0	0	0	0	0	0							1	0%
15	21	22	18	17	18	22	17	19	17	19	16	16	18	20	0	0	0	0	0	0	275	100%
Ethnicity																						
0	0	0	0	0	0	0	0	0	0	0	0	0	0	0							0	0%
11	10	22	17	15	16	20	15	17	15	18	14	13	18	18							239	87%
2	1	0	0	1	0	0	2	2	2	1	2	3	0	1							17	6%
0	0	0	0	0	0	0	0	0	0	0	0	0	0	1							1	0%
0	0	0	0	0	0	0	0	0	0	0	0	0	0	0							0	0%
0	0	0	0	1	0	0	0	0	0	0	0	0	0	0							1	0%
0	4	0	0	0	2	2	0	0	0	0	0	0	0	0							8	3%
2	6	0	1	0	0	0	0	0	0	0	0	0	0	0							9	3%
15	21	22	18	17	18	22	17	19	17	19	16	16	18	20	0	0	0	0	0	0	275	100%

15 presentations, 275 students

TEEN POSTPONE PREGNANCY
monterey county health department

ATTENDANCE FORM

Site Name: _____ **Teacher/Coordinator Name:** _____

Period # _____ **Presentation Date:**_____ **Name of Presentation:**_____

Name of Presenters: _____

***Race/Ethnicity:** **AA** – African American **L** – Latino/Hispanic **W** – White **A** – Asian **AI** – American Indian **PI** – Pacific Islander **O** – Other/Multi-Cultural

#	**Name** (First and Last) *Nombre(Primer y Apellido)*	**Age** *Edad*	**Gender** *Género*	***Race** *Raza*
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				

TEEN POSTPONE PREGNANCY
monterey county
health department

The POSTPONE Alisal High Student Mentors will be attending one full day training on October 15, 2021. Topics to be covered during the fall include: Healthy relationships, how to make good decisions, dating abuse, mental health awareness and services.

In class presentations will be at the end of October and November to the freshmen seminar classes.

Please sign below if you give permission to your student who is in good standing in your class, to attend training and present. It will be the student's responsibility to notify you of the date they will be presenting. Your signature acknowledges your consent for the student to participate and you are agreeing that the student will be able to make up any assignment they miss due to the presentation.

Please contact Ms. Cleaves, Room 535
Or Emiko Torres at MCHD 831-755-4629 torrese@co.monterey.ca.us if you have any questions. Thank you!
^^^

Name: ______________________________ **ID#:** _____________
By signing you acknowledge that the student has permission to present during your class period. The student will check in with you for any missed work.

Period	Class	Grade	Citizenship	Teacher	Signature
1					
2					
3					
4					
5					
6					

POSTPONE

Meetings every other Tuesday @ EAHS!!!!

- Peer Education
- Youth Leadership
- Community service hours
- Health Promotion

For more information:

Emiko Torres
831-755-4649
Or Stop by Ms. Jefferson's class

TEEN POSTPONE PREGNANCY
monterey county health department

POSTPONE

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TEEN POSTPONE PREGNANCY
monterey county health department

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monterey county health department

POSTPONE

Meetings every other Tuesday @ EAHS!!!!

- Peer Education
- Youth Leadership
- Community service hours
- Health Promotion

For more information:

Emiko Torres
831-755-4649
Or Stop by Ms. Jefferson's class

TEEN POSTPONE PREGNANCY
monterey county health department

Family PACT
Planning • Access • Care • Treatment
www.familypact.org

Salinas:
- **Alisal Health Center**
  (831) 769-8870, 559 E. Alisal Suite 202, 93906
- **Clinica de Salud**
  (831) 757-1365, 219 N. Sanborn Rd., 93906
- **Clinica de Salud**
  (831) 757-6237, 950 Circle Drive, 93906
- **Laurel Family Practice**
  (831) 755-4123, 1441 Constitution Blvd, Bldg. 400, 3rd Floor, 93906
- **Planned Parenthood Mar Monte**
  (831) 758-8261, 316 N. Main Street, 93906

Marina:
- **Monterey County Health Clinic at Marina**
  (831) 883-7558, 3155 De Forest Road, 93933

Seaside:
- **Seaside Family Health Center**
  (831) 899-8100, 1150 Fremont Blvd., 93955
- **Planned Parenthood Mar Monte**
  (831) 583-6700, 625 Hilby Ave, 93955

Castroville:
- **Clinica de Salud**
  (831) 633-1514, 10561 Merritt Street, 95012

Soledad:
- **Clinica de Salud**
  (831) 678-0881, 799 Front Street, 93960
- **Soledad Medical Clinic**
  (831) 678-2665, 600 Main Street, 93960

Greenfield:
- **Clinica de Salud**
  (831) 674-5344, 808 Oak Ave, 93927

King City:
- **Mee Memorial Clinic**
  (831) 385-7100, 210 Canal Street, 93930
- **Clinica de Salud**
  (831) 385-5944, 122 San Antonio Drive, 93930

NOTICE: Inclusion or exclusion of clinics in this directory does not imply recommendation or endorsement by MCHD or Family Pact. Please note that all information is subject to change. Contact 831-755-4695 for revisions. Revised on October 06, 2020.

Ciudate

Teen Pregnancy
Prevention Programs

Post-Poned Pregnancy

Monterey County Health Department
1441 Schilling Pl 1st Floor, Salinas, CA 93901
Emiko Torres Phone: 831-755-4649
torrese@co.monterey.ca.us

Crisis Hotlines

National Domestic Violence Hotline	800-799-7233
National Human Trafficking Hotline	888-373-7888
Poison Control	800-222-1222
Monterey County Rape Crisis (Salinas)	831-424-4357
24Hr (Monterey)	831-375-4357
YWCA of Monterey County (24Hr)	831-372-6300
	831-757-1001
Suicide Prevention Hotline	877-663-5433
National Suicide Prevention Hotline	800-273-8255

Mental Health Services

Behavioral Health Services CHOMP	831-625-4600
Monterey County Mental Health Access	888-258-6029
Monterey County Mental Health	831-755-4111

HIV Testing/ Services

Access Support Network	831-975-5016
Opus Clinic (Chomp)	831-625-4972
NIDO Clinic Natividad	831-796-1770
Monterey County HIV/ AIDS Services	831-755-4626

Drug & Alcohol Services

Al-Anon & ALA Teen (Spanish)	831-424-6207
(English)	831-373-2532
Alcoholics Anonymous (Salinas)	831-424-9874
(Monterey)	831-373-3713
Community Human Services	831-658-3811
Door to Hope	831-422-6226
Genesis House	831-899-2436
Off Main Clinic	831-424-4828
Sun Street Centers	831-753-5135
Syringe Exchange Program (ASN)	831-975-5016

Adoption Services

Kinship Center	831-455-9965
Family to Family	800-850-0006
Family Children Services	831-755-4475

If you are in need of other services not listed please call

211

Monterey County

Notice: Inclusion or exclusion of services in this directory does not imply recommendation or endorsement by MCHS. Please note all information is subject to change. Contact 831-755-4649 for revision. Revised on 12/09/19.

Date: _____ Period: _____ School: _____

Postpone Peer Health Education
Healthy Relationships

1. True or False (Circle one)
   To make a healthy decision, you must list your options and gather information.

2. How can you tell if you or someone is in an unhealthy relationship? (Circle one)
   a) Communication with one another
   b) Trust each other
   c) Checks your phone
   d) Respect each other's space

3. What is not a sign of reproductive coercion? (Circle one)
   a) Interfering with birth control
   b) Controlling outcome of pregnancy
   c) Pressuring partner to have unprotected sex
   d) Using condoms consistently and correctly

4. True or False (Circle one) The Monterey Rape Crisis Center offers resources for abusive relationships.

5. True or False (Circle one) Monterey County Behavioral health offers mental health services for teens?

Date: _____ Period: _____ School: _____

Postpone Peer Health Education
Healthy Relationships

1. True or False (Circle one)
   To make a healthy decision, you must list your options and gather information.

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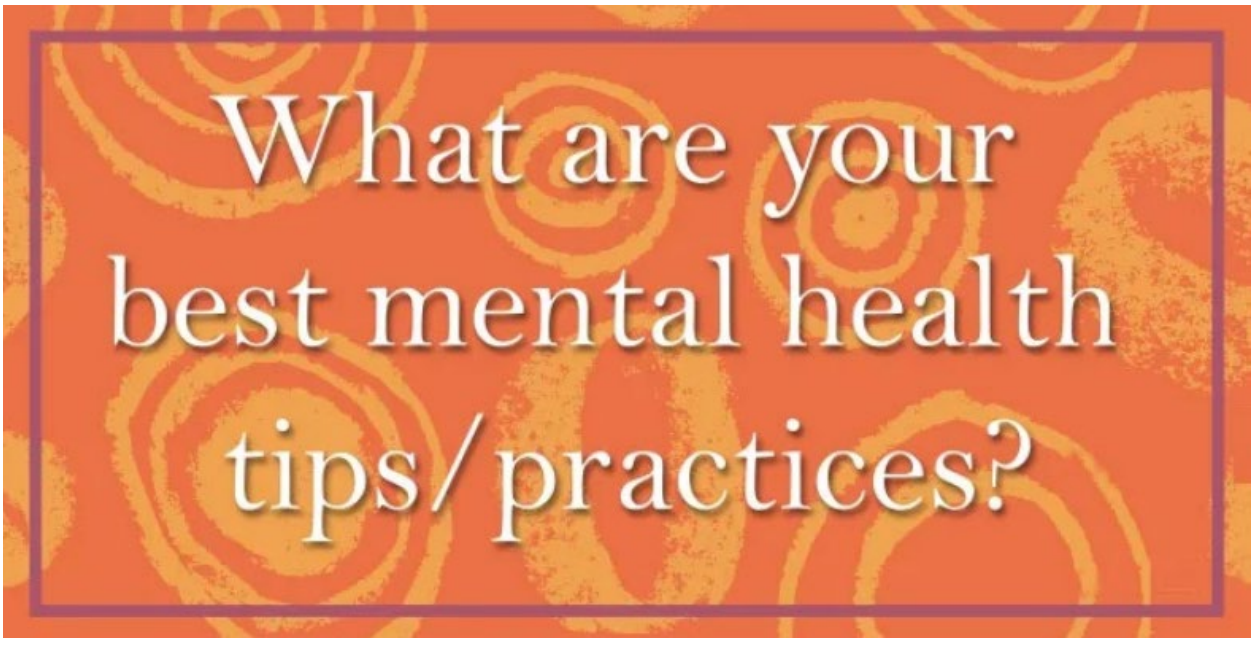
   e) Interfering with birth control
   f) Controlling outcome of pregnancy
   g) Pressuring partner to have unprotected sex
   h) Using condoms consistently and correctly

4. True or False (Circle one) The Monterey Rape Crisis Center offers resources for abusive relationships.

5. True or False (Circle one) Monterey County Behavioral health offers mental health services for teens?

Sample Posts


WHO DO I CALL?
FOR MENTAL HEALTH IN MONTEREY COUNTY?
1-888-258-6029



Community Human Services

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Program 7 - Micro Innovation Report

____Q1____

September 16, 2021 – Communications Manager facilitated presentations to the Migrant Education Program (MEP) districts of Chualar, Gonzalez and Santa Rita. Spoke to MEP parents about no cost mental health services for uninsured or those with Medi-Cal. CHS and MEP have partnered to distribute Spanish language mental health materials to hard-to-reach migrant families, to connect them with counseling support provided by Community Human Services. Estimated reach: 600.

____Q2____

October – December, 2021 – Tricolor Radio "Free Mental Health Counseling" Spots:

> *"COMMUNITY HUMAN SERVICES INVITA A LOS RESIDENTES SIN SEGURO DEL CONDADO DE MONTEREY A INSCRIBIRSE PARA RECIBIR CONSEJERIA GRATUITO PARA EL BIENESTAR MENTAL. ESTARAN DISPONIBLES CONSEJEROS BILINGUES PARA HABLAR SOBRE LA SALUD MENTAL, EL MENAJO DE ESTRES, DEPRESION, ANSIEDAD, Y BIENESTAR. NO SE PIERDEN ESTA OPORTUNIDAD. PARA PROGRAMAR UNA AVALUACION Y SERVICIOS SIN COSTO, LLAME AL 8-3-1—7-5-7—7-9-1-5."*

Analytics: Adults 18+ (Primary)
Impressions: 990,000
Net Reach: 55,400

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Community Human Services

Free Mental Health Campaign
2021

Station	Program	Time	Len.	Mon	Tue	Wed	Th	Fri	Sat	Sun	# of Wks	# of spots a week	Rate	Weekly Cost	Total Cost
KLOK	Early Morning Drive	5a-6a	30	x	x	x	x	x			9	4	$ 11	$ 44	$ 396
KLOK	Morning Drive	6a-10a	30	x	x	x	x	x			9	10	$ 15	$ 150	$ 1,350
KLOK	Midday	10a-3p	30	x	x	x	x	x			9	10	$ 17	$ 170	$ 1,530
KLOK	Afternoon Drive	3p-7p	30	x		x		x			9	3	$ 27	$ 81	$ 729
KLOK	Bonus on Mo-Fr ROS	6a-12a	30	x	x	x	x	x	x	x	9	15	$ -	$ -	$ -
	KLOK Totals											42		$445	$4,005

Air Dates: 10/15/21 – 12/15/21

TOTAL BREAKDOWN:
Total number of spots on KLOK: 42x a week X 9 weeks = 348 Total Spots
15 weekly bonus spots included
Total investment: $4,005

_____Q3_____

February – March, 2022

The MCOE Migrant Education Program (MEP) Manager invited CHS to provide 5 mental health focused workshops to parents and students. Presentations were scheduled as follows:

March 3, 2022	Gonzales High School, Gonzales
March 30, 2022	Del Rey School, King City
March 17, 2022	Greenfield High School, Greenfield
March 24, 2022	Santa Rita Elementary School
April 4, 2022	San Vicente, Soledad

Each workshop covered the following topics:

1. Identify the signs of stress and implement stress reduction practices
2. Implement mindfulness practices
3. Understand appropriate child and adolescent development (parents)
4. Understand the impacts of anxiety and depression on students' academic achievement (parents)
5. Understand the importance of healthy eating and exercise practices

Interested parties received fliers and were referred to utilize our no-cost short-term mental health counseling for uninsured individuals. Estimated reach: 800.

MEP Point of Contact:
Efrain Magallanes
Migrant Education Program, Manager
Monterey County Office of Education
901 Blanco Circle, Salinas, CA 93912
Desk: 831.755.6467 | Cell: 831.229.8680
emagalla@montereycoe.org

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Program 7 - Micro Innovation Report (2022)

_____Q4/Q1_____

June 2022-September 2022 – Community Human Services facilitated campaigns with La Preciosa and Tricolor radio stations in a "Lunchtime Giveaway" promotion to disseminate mental health information and free mental health services to Monterey County Latino/migrant families and farmworkers. The stations conducted bi-weekly contests to choose an Ag group of field workers to receive free lunch in the field and "Mental Health Gift Packs". Lunchtime giveaways were distributed by the station, the CHS Communications Manager, and other CHS staff in attendance.

The promotional activities were very successful: 9 lunchtime events were held during this period (6 in partnership with La Preciosa and 3 in partnership with Tricolor). Approximately 40 Mental Health Gift Packs and lunches were distributed per event to reach approximately 360 migrant farmworkers total. Giveaway events were held at the following farms:

- Camarillo Harvesting / South Salinas
- Sakai Farms / Spreckels
- The Growers Co. / Gonzales
- Braga Ranch / Soledad
- Carrazco Farms / Gonzales
- Mariani Farms /Castroville
- Tanimura & Antle / Salinas
- Merrill Farms / Salinas
- Oasis Berry Farms /Salinas

Mental Health Gift Packs were also disseminated at the Artichoke Festival on 6/11, and during both days of the Salinas Rodeo on 7/21 and 7/22.

- Artichoke Festival (giftpacks disseminated): 100
- Salinas Rodeo (giftpacks disseminated): 500 *(over 27,000 individuals attended the event)*

Targeted radio and Facebook mental health and cross-promotional ads ran from 6/1 – 9/30.

Facebook Campaign Data:

- Facebook Ad Impressions (6/1-10/3): 539,000
- Facebook Ad Reach (6/1-10/3): 151,000

Radio Ad Copy (Tricolor, IHeart, and La Preciosa):

"LA AGENCIA, COMMUNITY HUMAN SERVICES, INVITA A LOS RESIDENTES DEL CONDADO DE MONTEREY, SIN SEGURO MEDICO, A INSCRIBIRSE PARA RECIBIR CONSEJERÍA GRATUITO PARA EL BIENESTAR DE SALUD MENTAL. CONSEJEROS BILINGUES ESTARÁN DISPONIBLES PARA HABLAR SOBRE LAS SALUD MENTAL, EL MANEJO DE ESTRES, DEPRESION, ANSIEDAD, Y BIENESTAR. NO SE PIERDEN ESTA OPORTUNIDAD. PARA PROGRAMAR UNA EVALUACIÓN Y SERVICIOS SIN COSTO, LLAMEN A 831.757.7915 o 831.394.4622."

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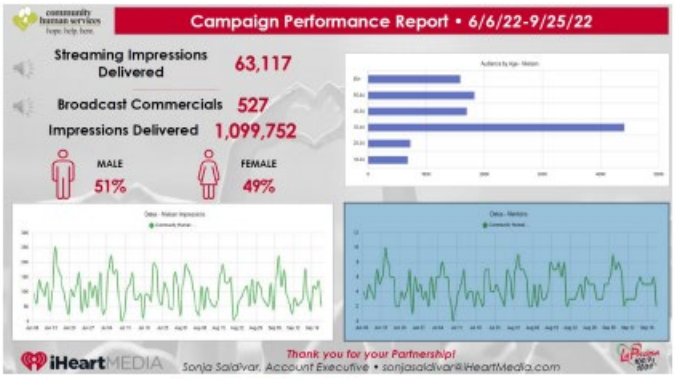
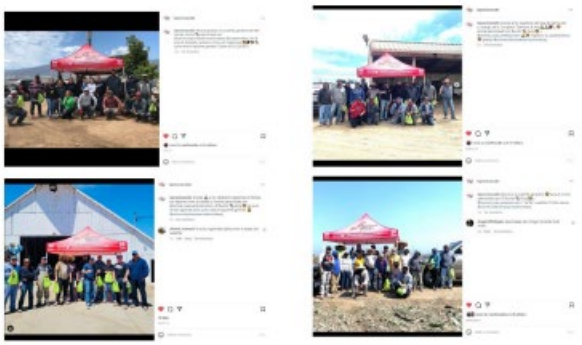
IHeart Campaign Data:



community human services
hope. help. here.

El Mañanero



KLOK/Tricolor Campaign Data:

KLOK/Tricolor Campaign Data (continued):

Community Human Services 2022

TAPSCAN

From: Maria Palacio
Phone: (831) 840-4806
Email: mpalacio@arbitron.com
10/12/2022 1:32 AM

Schedule Grand Totals: 8 Weeks

Stations	Spots	Unit Rate	Total Cost	Average Rating	Schedule Cume Persons	CPP	CPM	GRP's	Frequency	Net Reach	Ols
Radio Total	360	$15.28	$5,500.00	1.3%	97,200	$11.98	$4.93	459.2	13.4	68,600	1,131,000
KLOK-FM	264	$19.38	$5,116.00	1.0%	84,300	$11.14	$4.51	459.2	14.4	79,700	1,131,000
KLOK-FM Stream	96	$4.00	$384.00	0.0%	0	$0.00	$0.00	0.0	0.0	0	0

Detailed Sourcing Summary

Radio Market: MONTEREY-SALINAS-SANTA CRUZ
Survey: Nielsen Radio August 2022 (Jul4 - Aug4)
Geography: Metro
Daypart: Multiple Dayparts Used

Demo/Intab Populations:

Age/Gender	Socioeconomic	Population	Intab
Adults 18+ (Persons)	Blind + Hispanics/All	245,200	600

Stations User Selected
Additional Stations - - Estimates not reported because the station was not reported in the selected survey.

Estimates reported for dayparts which start and end between 12m and 5a are based on the 5a-5a broadcast day. Estimates for all other dayparts are based on the 12m-12m calendar day.
Please note: The intab reported is for the full twelve weeks of the survey. Users should note that reports run on fewer than twelve weeks are based on smaller sample sizes.
Stations qualify to be reported if they have received credit for five or more minutes of listening and meet a minimum reporting standard of 0.1 AQH unrounded rating in the Metro survey area, Monday-Sunday 6AM-Midnight, during the survey period. If a current Nielsen client does not meet this minimum reporting standard, Nielsen will report the station as long as credited listening is received from at least one diary keeper.
Estimates are derived from the diaries that provided the audience data for the Nielsen Radio Market Report and are subject to the qualifications and limitations stated in that Report. The TAPSCAN Web software product is accredited by the Media Rating Council and reports both accredited and non-accredited data. For a list of the accredited and non-accredited Nielsen radio markets and data available through TAPSCAN, click here: http://www.arbitron.com/downloads/MRC_Accredited_Services_Markets.pdf
The Reach and Frequency Model utilized by Nielsen is formulated on the bases of the Harris Model, a Linear Frequency reach-and-frequency model, and the Slide Rule audience (curve) growth model.

Actividades del programa subvencionado Micro-Innovación para aumentar la participación de los latinos en el marco del Plan de innovación

Informe final resumido de la evaluación anual

Enero de 2023

EVALCORP
Measuring What Matters℠

MONTEREY COUNTY
BEHAVIORAL HEALTH
Avanzando Juntos Forward Together

Tabla de Contenidos

Introducción

Monterey County Behavioral Health (MCBH) creó las Actividades del programa subvencionado de Micro-Innovación para aumentar la participación de los latinos en el marco del Plan de innovación (Micro-Inn). El proyecto Micro-Inn tiene por objeto descubrir métodos eficaces para mejorar el alcance y la prestación de servicios de salud mental a la población latina desatendida del condado. El proyecto, de tres años de duración, se amplió a cinco, en parte debido a la pandemia de COVID-19. El proyecto, financiado con fondos de la Ley de Innovación de Servicios de Salud Mental, comenzó en 2018 y finalizará en agosto de 2023.

MCBH contrató a EVALCORP para evaluar el impacto del proyecto Micro-Inn. La participación de EVALCORP en la evaluación comenzó en agosto de 2022. Este informe incluye información relacionada con el programa, así como una reseña de los métodos y resultados de la evaluación hasta el 30 de junio de 2022.

Proyecto Micro-Inn

El proyecto Micro-Inn se creó para abordar el problema del número relativamente bajo de latinos que utilizan los servicios de salud conductual en el condado. El programa pretendía abordar este problema posibilitando una red difusa de actividades de micro-innovación diseñadas específicamente por y para comunidades locales, barrios, subgrupos culturales o étnicos determinados, etc. Las actividades podrían ser puntuales o sostenidas, con una duración máxima de 12 meses. Para implementar este proyecto de Innovación, MCBH creó una solicitud de subvención, criterios de puntuación (Anexo A), y la Junta de Revisión de Subvenciones de Micro-Innovación para evaluar las solicitudes. MCBH también creó un formulario de seguimiento de referencias para que los beneficiarios lo utilicen en sus programas (Anexo B).

El principal objetivo de aprendizaje de este proyecto es determinar si alguna de estas actividades de micro-innovación es eficaz para atraer a la población latina a los servicios de salud mental necesarios. Los objetivos específicos de aprendizaje de este proyecto son:

- Para cada micro-innovación, identificar cuántas personas latinas recibieron una referencia para un tratamiento de salud mental y que nunca habían acudido para recibir servicios de salud mental.
- Para cada micro-innovación, identificar cuántas personas latinas dieron seguimiento a una referencia y recibieron servicios de tratamiento de salud mental.
- Identificar si el número total de latinos atendidos aumentó durante este proyecto de innovación.
- Identificar si alguna actividad de micro-innovación demuestra capacidad de sostenibilidad en cuanto a su impacto y/o financiamiento.
- Identificar si se abordaron las barreras culturales y de qué manera.

La Tabla 1 presenta las preguntas de evaluación para el Programa Micro-Inn, que están alineadas con los objetivos de aprendizaje del proyecto establecidos para la iniciativa, y la fuente de datos relacionada. Los resultados de los grupos de discusión con los beneficiarios no se incluyen en este informe porque aún no se han realizado.

Tabla 1. Preguntas de evaluación y fuentes de datos

Preguntas de evaluación	Fuente de datos
Para cada micro-innovación, ¿cuántas personas latinas que nunca habían acudido a servicios de salud mental recibieron una referencia para recibir servicios de tratamiento de salud mental?	Informes de evaluación de los beneficiarios
Para cada micro-innovación, ¿cuántas personas latinas dieron seguimiento a una referencia y recibieron servicios de tratamiento de salud mental?	Informes de evaluación de los beneficiarios
¿Aumentó el número total de latinos atendidos durante este proyecto de innovación?	Informes de evaluación de los beneficiarios
¿Alguna actividad de micro-innovación demostró capacidad de sostenibilidad en cuanto a su impacto y/o financiamiento?	Informes de evaluación de los beneficiarios y grupos de discusión
¿Cómo se abordaron las barreras culturales?	Informes de evaluación de los beneficiarios y grupos de discusión

Se solicitó a los beneficiarios el mantenimiento de los siguientes registros:

- Recuento del total de clientes
- Aspectos demográficos
- Recuento de personas que no habían recibido servicios de salud mental anteriormente
- Número de referencias
- Tipo de referencias
- Número de referencias en las que las personas sí dieron seguimiento y acudieron a una cita

Durante el AF 21/22 hubo tres rondas de solicitudes (rondas cuatro, cinco y seis). Las rondas uno, dos y tres se completaron en años fiscales anteriores y no se incluyen en este informe. Se financiaron 10 de las 16 solicitudes recibidas. En la Tabla 2 se muestra una reseña resumida de los proyectos financiados que se incluyen en este informe. Durante el AF 21/22 se denegaron seis proyectos (Tabla 3). Los motivos de denegación fueron, entre otros: actividades incoherentes con la intención o los requisitos del plan de innovación o la falta de varios componentes necesarios en las solicitudes para explicar el plan de ejecución y evaluación. Las descripciones completas de las solicitudes aprobadas y denegadas figuran en el Anexo C.

Tabla 2. Proyectos financiados en el AF 21/22

Beneficiario/Nombre del programa	Cantidad financiada solicitada/Gastada Período de implementación	Descripción de alto nivel
Ronda 4 (Proyectos finalizados)		
Michael Houston/Difusión de las Artes Culturales de Greenfield (Mi Vía, Mi Arte, Mi Alegría)	$5,850/$6,728 Febrero – Junio 2022	El proyecto organizó un stand y proporcionó entretenimiento culturalmente adaptado y centrado en la salud mental en ferias culturales en el sur del condado para las comunidades de trabajadores agrícolas migrantes.
Programa Door to Hope/Circle of Security para trabajadores agrícolas	$50,000/$50,000 Junio 2021 – Mayo 2022	El proyecto adaptó e impartió las clases del Circle of Security (COS) y las actividades de manejo de casos en español y triqui a trabajadores agrícolas migrantes y comunidades indígenas desatendidos y subatendidos. El programa COS pretendía fomentar relaciones de apego seguras entre padres e hijos.
Formación de liderazgo juvenil MILPA/Rancho Cielo	$50,000/$50,000 Julio 2021 – Junio 2022	El proyecto se centró en atender a jóvenes, principalmente latinos, del Rancho Cielo Youth Campus, un centro integral de aprendizaje y servicios sociales para jóvenes menos atendidos del Condado de Monterey. Bajo el concepto general de Telpochcalli, se proporciona apoyo y servicios de salud mental culturalmente pertinentes a los jóvenes afectados por el sistema. En el entorno virtual estructurado, Telpochalli tomó referencias de admisión, implementó servicios y refirió a los participantes a los servicios de salud mental de MCBH.
Emeralda Owen/Anuncios de servicio público	$50,000/$50,000 Julio 2021 – Mayo 2022	El proyecto proporcionó anuncios de servicio público (PSAs) mensuales en español para emisoras de radio y televisión en español, además de una hora de entrevista trimestral en la radio en español.
Ronda 5 (Proyectos finalizados)		
Oficina de Salud Pública del Condado de Monterey (MCPHB)	$50,000/$36,166 Agosto 2021 – Junio 2022	El proyecto elaboró un plan educativo para abordar las necesidades de salud mental de los jóvenes en las escuelas secundarias de Alisal y Everett Alvarez del Distrito de Escuelas Secundarias de Salinas Union. El plan

		incluyó la formación de un mínimo de 30 educadores entre pares mediante el currículo Mind Matters™, la contratación de un estudiante en prácticas de salud pública y un alcance de 1,000 estudiantes mediante presentaciones en las aulas. En el transcurso de las actividades de implementación se proporcionó información y referencias a los servicios locales de salud mental.
NAMI*	$22,300/$0	El capítulo del Condado de Monterey propuso la puesta en marcha de un programa para ayudar a los residentes indocumentados de habla hispana a buscar servicios de salud mental. El programa debía incluir una serie de cinco presentaciones en español en locales comunitarios.
Servicios Humanos Comunitarios	$50,000/$50,000 Octubre 2021 – Septiembre 2022	El proyecto consistió en una colaboración con el Programa de Educación para Migrantes de la Oficina de Educación del Condado de Monterey para ofrecer talleres de salud mental para padres y estudiantes.
Ronda 6 (Proyectos actualmente implementados)		
Door to Hope	$50,000 Julio 2022 – Junio 2023	El proyecto incorporó un terapeuta trilingüe al distrito escolar de Greenfield, donde están matriculados un número sustancial de hijos de trabajadores agrícolas migrantes, para atenderles mejor a ellos y a sus familias.
United Way Monterey County (UWMC)	$50,000 Septiembre 2022 – Enero 2023	El proyecto consistió en capacitar promotores en el uso de la herramienta Smart Referral Network de UWMC. El proyecto se lleva a cabo en colaboración con el Boys and Girls Club Monterey.
Precious Stone PR, Inc.	$50,000 Junio 2022 - Mayo 2023	En el marco del proyecto se crearon anuncios de servicio público mensuales en español, tipo novela, para emitirlos en las cadenas locales de televisión en español.

* El solicitante retiró su interés antes de llegar a un acuerdo con MCBH debido a la falta de capacidad de personal.

Tabla 3. Proyectos denegados AF 21/22

Solicitante/Nombre del programa/ Cantidad solicitada	Descripción de alto nivel
Ronda 4	
Jorge Rojas/ Monterey County Soccer Club/$50,000	Una organización de la liga de fútbol local propuso ayudar a la comunidad de futbolistas para recibir recursos de primera necesidad y de salud mental. El solicitante tenía previsto desarrollar un equipo capacitado en servicios de atención a la salud mental para atender a los 6,000 miembros de la organización de fútbol. La propuesta se centraba en generar confianza mediante la entrega a los miembros de medios para satisfacer las necesidades básicas (por ejemplo: comida, agua, resguardo, ropa). Una vez cubiertas las necesidades básicas, el plan consistía en ofrecer información sobre servicios de salud mental e información de referencias.
Rocío Quintero/Difusión en toda la ciudad de Gonzales	El Distrito Escolar Unificado de Gonzales y la municipalidad de Gonzales propusieron un proyecto para que la comunidad latina local participara en servicios de salud mental por medio de diversas actividades. Estas actividades incluían clases de pintura, grupos de apoyo y rincones de tranquilidad.
Emeralda Owen/Precious Stone PR, Inc.	El proyecto propuesto era una idea de marketing digital que implicaba la creación de contenidos digitales y diseños gráficos para difundir información sobre los servicios de salud mental en el Condado de Monterey.
Ronda 5	
Universidad Estatal de California en Monterey Bay (CSUMB)	Un estudiante de una universidad local propuso grupos de discusión, facilitados por estudiantes de asistente médico de la CSUMB, para los trabajadores agrícolas migrantes en el sur del Condado de Monterey. Los grupos de discusión incluirían un currículo de herramientas como la atención plena, la meditación y la descentración cognitiva. Estas herramientas estaban destinadas a ayudar a los trabajadores agrícolas a hacer frente a los problemas de salud mental hasta que pudieran acudir a su proveedor.
Plan AIM de salud mental de los jóvenes	Una organización local sin ánimo de lucro orientada a los jóvenes propuso un plan para un programa piloto de investigación y acción participativa con el fin de ampliar la educación, prevención e intervención en materia de salud mental con estudiantes de secundaria, orientadores juveniles, padres y organizaciones al servicio de los jóvenes en el Condado de Monterey. El objetivo era involucrar a los jóvenes en conversaciones sobre salud mental, fomentar la defensoría, sensibilizar y educar a los jóvenes en soluciones basadas en evidencia. Este proyecto buscaba la participación de jóvenes de entre 14 y 18 años, haciendo énfasis en atender a estudiantes de inglés como segunda lengua y a quienes viven en condiciones de pobreza.
Ronda 6	

Majesh Natrajan	La sanación con sonido (cuencos tibetanos) pretendía introducir en el Condado de Monterey la práctica de un tratamiento holístico de meditación con sonido basado en la atención plena para aliviar los síntomas de los problemas de salud mental. Se haría con una estructura de meditación multisensorial inmersiva a demanda, llamada "Heal". Heal utiliza la terapia de sonido como "ruedas de aprendiz" para una sólida base de práctica de meditación a largo plazo que permite a los participantes comprometerse de forma consciente.

Métodos de evaluación

La evaluación de Micro-Inn está diseñada para responder a las preguntas de aprendizaje y evaluación planteadas para el proyecto e incluye estrategias de recolección de datos cualitativas y cuantitativas. Los datos utilizados para la evaluación provienen de los informes presentados por los beneficiarios que finalizaron sus proyectos durante el AF 21/22. Al momento de redactar este informe cinco beneficiarios habían presentado sus informes; uno seguía pendiente (MILPA /Capacitación de liderazgo juvenil de Rancho Cielo). Los proyectos restantes están en curso y, por lo tanto, los beneficiarios aún no han redactado los informes de evaluación.

Limitaciones

Como ocurre con cualquier evaluación, la de Micro-Inn se enfrentó a limitaciones impuestas por las circunstancias. El equipo de EVALCORP no participó en la evaluación de los cuatro primeros años del proyecto. Debido a las dificultades para recopilar datos, solo uno de los beneficiarios presentó datos de referencias y dos presentaron datos demográficos. Algunos impactos de los proyectos, como los de los anuncios de servicio público, no pueden proporcionar información sobre el número de personas a las que se ha llegado o que han recibido servicios como resultado del programa. Por último, los proyectos incluidos en Micro-Inn pueden tardar en generar alguna influencia en la búsqueda de servicios de salud mental y los impactos quizá sean evidentes en evaluaciones posteriores en el largo plazo.

Descubrimientos

Las referencias de la población latina a los servicios de salud mental era uno de los principales objetivos del proyecto Micro-Inn. Door to Hope (n = 32) pudo recopilar datos de referencias para mostrar que aproximadamente un tercio (38 %, n = 12) de los participantes fueron referidos a servicios de salud mental; nueve participantes fueron establecieron contacto exitosamente con servicios de salud mental y siguen viendo a su terapeuta con regularidad. También se realizaron otras referencias, como educación para padres, bancos de alimentos, asistencia financiera, etc. Dos programas hicieron un seguimiento de la información demográfica y cuatro pudieron hacer un seguimiento del alcance (Tabla 4).

Tabla 4. Alcance y demografía por proyecto, AF 21/22

Nombre del proyecto/Costo del programa	Alcance	Aspectos demográficos
Mi Vía, Mi Arte, Mi Alegría/$6,728	285 asistentes a seis eventos	*Etnia (n = 129)** 86 % Mexicano/Mexicana (n = 112) 34 % Latinoamericanos (n = 44) 6 % Indígenas (n = 8) 5 % Blancos (n = 6) *Edad en años (n = 87)* 20 % 0-12 (n = 17) 8 % 13-20 (n = 7) 29 % 21-35 (n = 25) 44 % 36+ (n = 38) *Sexo (n = 94)* 59 % mujeres (n = 55), 41 % hombres (n = 39) *Puede seleccionar más de una respuesta
Door to Hope/$50,000	32	100 % Hispano/Latino
MILPA/Formación de liderazgos juvenil de Rancho Cielo/$50,000	Informe pendiente	Informe pendiente
Emeralda Owen/$50,000	Desconocido	Desconocido
Oficina de Salud Pública del Condado de Monterey/$36,166	Para el programa Mind Matters, se formó a 65 educadores entre pares y se realizaron 77 presentaciones; los educadores entre pares llegaron hasta 1,740 jóvenes no duplicados. El programa Postpone, un programa que aborda el embarazo en adolescentes, llegó hasta 1,000 jóvenes. No se dispone de análisis en redes sociales.	Desconocido
Servicios Humanos Comunitarios/$50,000	Estimados 208760	Desconocido

Resumen de los resultados e impactos de cada proyecto

Mi Vía, Mi Arte, Mi Alegría. El beneficiario, situado en el sur del condado, recurrió a artistas de la comunidad para que compartieran experiencias y contrarrestar así las actitudes de estigmatización asociadas a los problemas de salud mental. Artistas comunitarios reconocidos promovieron el acceso a servicios de salud mental en un entorno seguro y apropiado para las familias. Las actuaciones en vivo permitieron a los artistas compartir sus experiencias de vida en relación con los problemas de salud mental y su recuperación. El público y los presentadores del proyecto eran trabajadores agrícolas oaxaqueños e hispanohablantes, y personas residentes en el Condado de Monterey, en Salinas, Greenfield y King City. Los actos incluyeron diálogos con el público sobre temas como el valor del arte como sanación, el valor de la alegría en la danza, la importancia de las actividades sociales artísticas para los niños y cómo la música salvó de la depresión a una cantante después de sufrir una lesión como trabajadora agrícola en Greenfield. Se incluyeron poesías, canciones y bailes.

El beneficiario elaboró una encuesta que se distribuyó en cada acto. Los asistentes llenaron la encuesta, en la que se pedía información demográfica, sobre la infelicidad y sobre el valor de los servicios sociales en español. El objetivo de la encuesta era ayudar a los encuestados a determinar si debían buscar referencias de servicios de salud mental para ellos mismos, sus amigos o sus familias. El 94 % de los encuestados (n = 141) afirmó que asistiría a otro evento en el futuro. Cuando se les preguntó si tenían amigos o familiares que se sentían infelices, 35 de los 121 encuestados (29 %) seleccionaron la opción de respuesta “sí” y el 100 % (n = 82) contestaron que les gustaría recibir ayudaen español de servicios sociales.

Perspectivas de evaluación. El programa contó con una buena asistencia (n = 285) y tuvo un costo bajo para el alcance relativamente alto. Tiene potencial para ser autosuficiente. Las actividades tenían fuertes componentes culturales e incluyeron a miembros reconocidos de la comunidad. En general, la población latina es una cultura que cuenta historias, por lo que es de esperar que haya tenido eco entre ellos.

Door to Hope. La organización ofreció las clases de Circle of Security durante ocho semanas y servicios de manejo de casos. Se impartieron cuatro sesiones de ocho semanas. El programa está basado en grupos, y unos 10 padres participaron en una reunión virtual de dos horas semanales durante ocho semanas. Dos facilitadores y un coordinador asistieron a cada reunión. Se realizaron doce referencias a servicios de salud mental (tres a la línea de acceso, seis al programa de salud mental no asegurado de Community Human Services, una a Beacon Health, una al programa integrado de salud mental de Door to Hope y una a un proveedor de seguros privado). Nueve participantes se comunicaron con éxito con los servicios de salud mental y siguen viendo regularmente a su terapeuta. Otras referencias que se realizaron incluyen educación para padres, bancos de alimentos, ayuda financiera, etc.

"Ofrecer clases de Circle of Security a las comunidades latinas desatendidas y subatendidas fue una forma fundamental de empezar a explorar los componentes básicos de la salud mental y la información con una población que tiene un acceso limitado a la educación y recursos de salud mental".

- Administrador del Programa Circle of Security

Los participantes compartieron las siguientes afirmaciones, que indican que reflexionaron y analizaron lo aprendido en las sesiones:

- "Solía gritarle a mi hija cuando lloraba, y ella lloraba aún más, pero ahora cuando le hablo suavemente e intento entenderla con preguntas, se calma".
- "A mi hija le gusta mucho explorar, pensaba que era traviesa, pero ahora sé que solo quiere aprender".
- "Tengo odio en el corazón por la forma en que me trataron mis padres cuando era niña. Y a veces siento que hago lo mismo con mis hijos y tengo miedo de perderlos".

Perspectivas de evaluación. El programa tuvo éxito en la referencia de casos y el currículo es pertinente desde el punto de vista cultural. El programa es impactante para los padres y sus relaciones consigo mismos y con sus hijos. El programa podría autofinanciarse si se cobra a los participantes una cuota por participar que no sea prohibitiva incluso para aquellos con ingresos bajos.

Emeralda Owen/Anuncios de servicio público. Doce anuncios de servicio público (PSAs) mensuales relacionados con la salud mental se emitieron en español. No se facilitó información sobre el alcance o impacto potencial de los anuncios.

Perspectivas de evaluación. La falta de datos no ha permitido determinar el impacto del programa. No se espera que el programa sea autosuficiente aunque los anuncios se emitan gratuitamente, debido a los gastos que supone su elaboración.

Oficina de Salud Pública del Condado de Monterey. La MCPHB impartió dos programas: Mind Matters y Postpone. Los currículos y los componentes de capacitación de Mind Matters y Postpone se adquirieron en el Instituto Dibble. Mind Matters se implementó para ayudar a los jóvenes a superar la adversidad y fomentar la resiliencia. Mind Matters ha sido utilizado por otros organismos para prevenir la violencia, abordar el ausentismo crónico y crear una cultura de bienestar. Postpone, un programa de prevención de embarazos en adolescentes, proporcionó formación, educación y recursos en las áreas de salud mental y servicios de prevención de embarazos en adolescentes. Los objetivos y resultados del programa figuran en la Tabla 5.

Tabla 5. Objetivos y resultados

Objetivos	Resultados
Formar a un mínimo de 30 estudiantes de secundaria de los institutos Alisal y Everett Alvarez y a un estudiante universitario en	Se brindó formación a sesenta y cinco educadores entre pares.

prácticas para que actúen como educadores entre pares.	
Llegar a 1,030 estudiantes de los institutos Alisal y Everett Alvarez mediante presentaciones en clase.	Se ofrecieron 77 presentaciones a 1,740 estudiantes.
Referir a los servicios al 10 % de los jóvenes contactados (103 jóvenes en virtud del objetivo original).	No se pudo dar seguimiento con precisión a este número.

Los éxitos asociados con este proyecto incluyeron el inicio de conversaciones y el intercambio de información con los jóvenes sobre la salud mental y la búsqueda de servicios de salud mental. Los programas ofrecieron a los jóvenes un espacio seguro para escuchar y normalizar el tema de la salud mental. Algunos jóvenes compartieron sus propias experiencias, y esto le recordó a otros estudiantes que los problemas de salud mental son comunes, y que hay apoyo disponible.

Los educadores entre pares declararon que les gustaba mucho el contenido de Mind Matters. La información que aprendieron fue compartida con otros a través de publicaciones en las redes sociales y durante conversaciones individuales con los estudiantes. Los educadores entre pares también informaron que utilizaban la información aprendida para ayudar a sus hermanos y amigos. Los educadores entre pares aprendieron a identificar algunas de las señales, como la baja en el rendimiento escolar, las malas notas, la ansiedad constante, el retraimiento social o la agresividad, las cuales pueden indicar la necesidad de recibir servicios de salud mental. El currículo de Mind Matters ayudó a eliminar barreras no solo a nuestros educadores entre pares de Postpone, sino también a facilitadores y alumnos de todos nuestros programas de prevención del embarazo en adolescentes. El currículo ayudó a desarrollar habilidades en los educadores que se transfirieron a los demás mediante interacciones individuales.

Los educadores entre pares de Postpone realizaron actividades de divulgación individualizadas con sus compañeros, documentaron sus interacciones y publicaron mensajes positivos sobre el acceso a los servicios de salud mental, consejos sobre salud mental y recursos de salud mental en sus cuentas personales de redes sociales (por ejemplo, Instagram, Snapchat). Los mensajes pretendían reducir la estigmatización y aumentar la comprensión de los recursos y servicios de salud mental. Los adolescentes suelen acudir a otros adolescentes en busca de ayuda sobre temas como la salud reproductiva, las tareas escolares, el empleo, etc. El programa Postpone utilizó un modelo de educación entre pares y los estudiantes recibieron información precisa y recursos de sus pares. Se asignaron educadores entre pares a las aulas para hablar de temas como la depresión, la ansiedad y la salud mental, con el fin de normalizar el debate sobre los servicios de salud mental y aumentar la probabilidad de que los jóvenes en las aulas soliciten servicios de salud mental.

Perspectivas de evaluación. El programa involucró a los estudiantes en debates sobre salud mental y podría conducir a un mayor comportamiento de búsqueda de ayuda entre nuestros jóvenes. La relevancia cultural está relacionada con tener el modelo de pares. Los pares tienen culturas generacionales similares y pertenecen a la misma comunidad. El costo de los currículos sería una cuota única, además de una cuota por el diario del participante. Estas partidas de costos podrían incorporarse al presupuesto escolar y el programa podría ser sostenible. El evaluador no está

seguro de si los diarios son necesarios para impartir el programa.

Servicios Humanos Comunitarios. La organización facilitó talleres sobre salud mental en colaboración con Migrant Education Program (MEP) de la Oficina de Educación del Condado de Monterey, difundió materiales y emitió anuncios por radio. Los temas incluyeron:

- Servicios de salud mental gratuitos para personas sin seguro o con Medi-Cal (para padres)
- Cuñas publicitarias en Radio Tricolor sobre "Asesoramiento gratuito sobre salud mental"
- Talleres (cinco) sobre temas de salud mental para padres y estudiantes
- Emisoras de radio Tricolor en una promoción de "Regalos a la hora de comer" para difundir información sobre salud mental y servicios gratuitos de salud mental a familias latinas/migrantes y trabajadores agrícolas del Condado de Monterey
- Se distribuyeron paquetes de regalo sobre salud mental en el Festival de la Alcachofa el 11 de junio de 2022 y durante los dos días del Rodeo de Salinas el 21 y 22 de julio de 2022.
- Los anuncios de salud mental y promoción cruzada de Facebook se publicaron del 1 de junio al 30 de septiembre de 2021; impresiones de anuncios: 539,000; alcance de los anuncios: 151,000.

Su difusión en el primer trimestre (cuando compartieron materiales sobre salud mental) tuvo un alcance estimado de 600 personas, el anuncio en la radio pública del segundo trimestre llegó a 55,400, el alcance de los talleres del tercer trimestre (cinco) se estimó en 800, y en el cuarto trimestre, las actividades en festivales y eventos llegaron aproximadamente a 960 personas. El beneficiario también publicó anuncios en Facebook que llegaron hasta 151,000 personas en cuatro meses.

Perspectivas de evaluación. El alcance de estas actividades fue elevado. Los datos disponibles no permiten determinar el impacto.

Discusión

En esta sección del informe se abordan los temas del alcance, las referencias, la sostenibilidad y los programas culturalmente adaptados.

Alcance Los proyectos llegaron a su público objetivo, que era la población latina, con base en los limitados datos demográficos disponibles. Los anuncios en los medios de comunicación y la radio tuvieron un amplio alcance, al igual que el programa de artes escénicas. En las clases de Circle of Hope para padres ofrecidas por el programa Door to Hope tuvieron un alcance menor, pero dieron lugar a varias referencias a servicios de salud mental y de otro tipo. Los programas de la MCPHB tuvieron un alcance significativo entre los jóvenes. El programa de Servicios Humanos Comunitarios también tuvo un alcance significativo.

Referencias. Los datos sobre el número de referencias para aquellos que nunca han acudido a los servicios de salud mental, el número de personas que dieron seguimiento a la referencia y el recuento total de latinos atendidos durante este proyecto de Innovación son relativamente desconocidos, ya que la información solo está disponible para un programa (el programa Door to Hope dio lugar a 12 referencias a los servicios con un 28 % [n = 9] de los asistentes que siguieron acudiendo regularmente a un terapeuta). Es posible que estos proyectos hayan tenido

repercusiones en los servicios de salud mental del público objetivo. Los programas pueden haber animado a los participantes a involucrarse en actividades de prevención o intervención temprana de problemas de salud mental. Además, es posible que hayan abierto la puerta a la posibilidad de considerar un tratamiento en el futuro o de comprometer a familiares y amigos a participar en actividades que promuevan la salud mental o a buscar ayuda para sí mismos.

Sostenibilidad. En cuanto a la sostenibilidad, el programa de artes escénicas fue rentable en términos de dólares gastados y el alcance logrado. Tiene potencial para ser autosuficiente. Las entradas podrían venderse a un precio razonable, es posible que los artistas actúen gratuitamente y que los locales donen o permitan el uso de espacios a bajo costo. Se necesitan estrategias de evaluación más rigurosas para valorar su impacto en los asistentes en términos de perspectivas sobre la salud mental, en la capacidad para aplicar estrategias de mejora y en la búsqueda de servicios. Las clases de Circle of Hope de Door to Hope, aunque parecían ser eficaces, resultaban muy costosas ($50,000) para el número de participantes (n = 32; una media de ocho por sesión de ocho semanas). Los demás programas tuvieron mayor alcance por la misma cantidad o por menos dinero. Quizá valga la pena examinar si las clases de Circle of Hope pueden impartirse con menores costos. Los programas de la MCPHB se ofrecen en las escuelas y podrían incorporarse al presupuesto escolar. El costo no es prohibitivo.

Adaptados culturalmente. Los programas utilizaron diversos métodos para abordar las barreras culturales, incluido el idioma. El programa Mi Vía, Mi Arte, Mi Alegría incorporó experiencias de vida sobre cómo los latinos superaron barreras e incorporó el diálogo sobre la salud mental. El programa incluyó cuentos, poemas y música con raíces culturales. El programa Door to Hope exploró lo que una persona ya sabe o ha experimentado en torno a las relaciones positivas, de modo que la organización pudo conocer las distintas prácticas que los padres ya utilizan para procesar los problemas de salud mental. Por ejemplo, las culturas y comunidades ya tienen ideas y rituales de salud mental y ahora necesitan espacios en sus nuevas comunidades del Condado de Monterey para practicar sus tradiciones autóctonas que les ayudan a sanar su mente y su cuerpo. Cuando las personas tienen recursos en sus comunidades que reflejan quiénes son y de dónde vienen, están más dispuestas a aceptar ayuda y apoyo cuando lo necesitan.

"...nos enteramos de que la comunidad Triqui participa históricamente en rituales similares con un *temazcal* o "cabaña de sudor" cuando se necesita sanar el cuerpo y el espíritu. También tienen líderes que guían a la persona para que regrese a recuerdos o experiencias dolorosas que le "robaron" su espíritu positivo y procese esas experiencias negativas para devolverle su espíritu positivo".

– Administrador del Programa Circle of Hope

Los programas de la MCPHB eran culturalmente pertinentes, ya que utilizaban un enfoque entre pares. Los pares son de la misma edad, cultura generacional, escuela y comunidad. Ser de la misma escuela y comunidad significa probablemente que existen similitudes culturales en cuanto a uno o varios de estos factores: raza, etnia, edad, estatus socioeconómico y geografía.

Recomendaciones

Las recomendaciones están relacionadas con el seguimiento de las referencias, la evaluación adicional de prácticas prometedoras, la calidad del número de referencias de Salud Conductual y el proceso de referencias escolares. La MCBH no puede hacer algunos de estos cambios, pero tal vez puedan hacer recomendaciones a las personas pertinentes.

Seguimiento de las referencias. Esto supuso un desafío por varias razones, como la vergüenza, el miedo, el bochorno y el estigma. Además, es posible que un participante no busque servicios al haber aprendido formas de manejar por sí mismo su problema de salud mental a través del programa o que el participante busque servicios en el futuro, lo cual sería de difícil seguimiento.

Otra razón por la que el seguimiento de las referencias es difícil está relacionada con el anonimato y la confidencialidad en torno a las referencias y las citas. Door to Hope manifestó que los jóvenes no deseaban compartir, ni siquiera con los educadores entre pares con los que habían entablado relación, ninguna información sobre el acceso a los servicios de salud conductual. Los estudiantes recomendaron la implantación de servicios que permitieran a los jóvenes acceder a la atención y el apoyo de forma anónima, si fuera posible. Los estudiantes estaban preocupados por la confidencialidad de su información/registro, de forma similar a las preocupaciones que tienen los estudiantes cuando el personal los refiere a las clínicas del Pacto de Familia para citas médicas. A los estudiantes les preocupa quién tendrá acceso a su expediente, concretamente si uno de sus padres podría acceder al expediente. Se necesitan más servicios de educación e información para los estudiantes sobre el derecho a la privacidad cuando solicitan servicios de salud conductual.

La recomendación es no utilizar las referencias como base para evaluar el impacto de los programas debido a las dificultades que plantea su seguimiento. Se sugiere utilizar otras métricas.

Prácticas prometedoras. Los programas Mi Vía, Mi Arte, Mi Alegría, Door to Hope, Circle of Hope, Postpone y Mind Matters han demostrado ser prometedores, pero no es posible determinar el verdadero impacto de los programas con los escasos datos disponibles. Se recomienda realizar evaluaciones adicionales de estos programas en el futuro, si fuese factible. Para el programa Circle of Hope, es necesario un análisis que permita determinar el costo de un curso de ocho semanas.

Número para referencias de salud conductual. Un beneficiario informó que, durante los seguimientos, algunos jóvenes dijeron haber oído hablar a otros jóvenes de un “mal servicio” cuando llamaban al número para referencias de salud conductual. No se brindaron más detalles al respecto. Debido al contexto de la discusión, el programa considera que esta información podría haber provenido de estudiantes a los que la persona que contestaba el teléfono de salud conductual les solicitó información que podría identificarlos. En otras palabras, los estudiantes pueden haberse sentido desanimados a buscar ayuda por tener que suministrar sus datos de identificación. Otros estudiantes informaron que habían recibido la ayuda que necesitaban al llamar al número de salud conductual, aunque no estaba claro cuándo habían llamado o si habían solicitado servicios durante el plazo del proyecto. Quizá sea valioso explorar la calidad y las prácticas de la asistencia de salud conductual. El mismo beneficiario señaló que los estudiantes se sentían confundidos con el proceso de derivación y admisión, y no entendían si debían volver a llamar o si alguien les devolvería la llamada.

Además, los educadores entre pares del programa Postpone informaron que varios estudiantes indicaron que se sentían más cómodos buscando servicios en la escuela (por ejemplo, el centro de bienestar escolar) en vez de llamar a una clínica de salud conductual, porque no sabían quién estaría al otro lado de la línea telefónica y temían ser juzgados.

Un beneficiario señaló que el personal comprendió que para responder mejor a esta población, debe haber una forma más instantánea de referir a los estudiantes directamente a un profesional de turno. Los jóvenes recomendaron un número de referencia que estuviese dedicado a los adolescentes y al que se pudiera acceder por SMS (la ventaja que señalaron sería que podrían recibir apoyo inmediato, lo cual "no daría tanto miedo como llamar y hablar con alguien"). Aunque existen líneas de texto para crisis a disposición de los jóvenes a través de recursos nacionales y estatales, el personal y los educadores entre pares desconocían las opciones de texto locales para los jóvenes que buscan apoyo continuo en materia de salud mental en una situación que no es de crisis. Una opción de texto local para adolescentes es altamente recomendable.

Proceso de referencias escolares. Los estudiantes compartieron sus preocupaciones y confusión sobre los procedimientos/políticas de la escuela con respecto a cómo acceder a los servicios de salud conductual o de asesoramiento. Los estudiantes comentaron que cada escuela parecía tener procedimientos diferentes. Los estudiantes también expresaron su preocupación por los "obstáculos adicionales e innecesarios", como el requisito de ver a su consejero escolar antes de que se les "permita" ir a la clínica de bienestar o acudir a otra persona de apoyo de salud mental (en una escuela). Se recomienda aumentar la información sobre el papel del orientador escolar en las escuelas secundarias y su función a la hora de referir a los estudiantes a servicios de salud conductual. Algunos estudiantes que compartieron información con los educadores entre pares también afirmaron que los formularios de admisión eran difíciles de llenar.

Resumen

Micro-Inn pretende referir a la población latina a servicios de salud mental. En su mayor parte, la falta de datos disponibles no permitió evaluar si se produjeron referencias, pero se obtuvieron ideas a partir de las lecciones aprendidas y se hicieron recomendaciones. Los programas llegaron hasta un gran número de personas y se identificaron un par de posibles programas prometedores. Es necesaria una evaluación en profundidad de los programas prometedores.

Appendix A: Grant Application Form and Scoring Criteria

Application for Micro-Innovation Grant

Monterey County Behavioral Health (MCBH) is currently offering a funding opportunity for one-time projects that may increase the engagement of Latino communities with our local mental health services system. For several years, health record data for Monterey County has indicated Latino communities to be the most underserved in our county. Extensive community feedback has indicated this may be due to current services not resonating with the various Latino ethnicities, languages and dialects, and cultural norms that exist across our large county. In response to this feedback, MCBH has obtained Mental Health Services Act (MHSA) Innovation funding to support individuals and organizations across Monterey County to try out their own unique approach to promoting mental health services in ways that better reach their Latino ethnicity, culture, language, city, neighborhood, etc. As a result, it is hoped that more culturally appropriate and impactful mental health service delivery and communication methods will be uncovered.

MHSA Innovation funding is intended for testing out new "out-of-the-box" ideas that can improve our mental health system. These projects can test out a new practice or approach to delivering mental health services, adapt an existing mental health service to better serve a group of people, or promote better communication and collaboration between agencies and organizations to make services more accessible and/or provide better quality services. It is not necessary for these projects to demonstrate success (although that's desirable!); but rather, it is most important to learn from the successes and failures of the ideas to better inform the mental health services community on best practices.

Micro-Innovation Application Requirements:

1. All activities must be new! Innovation funds are dedicated for testing new and novel concepts and may not be used to supplement existing programs or activities.
2. Eligibility: All members of our community are encouraged to apply, including members of the public, past and current clients, affected family members, students, community partners and service providers.
3. Budget: Activities may be small or large in scope, with budgets ranging from $500 to $50,000. Please note that funds received must be reported to the IRS as personal income and recipients will receive a 1099 tax form at the end of the year to assist in tax preparation.
4. Timeline: Activities may be a one-time event or a continuous activity lasting up to one year. Timelines should account for planning for the activity, implementing the activity, and organizing activity information for evaluation efforts.

Applications Rating Criteria:

A. Level of Innovation – Creativity and unique solutions to address community-specific needs is encouraged.
B. Evaluability – Being able to articulate the work to be done and the anticipated results of that work is very important, as it allows evaluation to occur on impact and cost-effectiveness.
C. Scalability – It is desirable for projects to be able to support an increased number of clients/participants
D. Population to be served – Projects will be awarded additional points for serving communities identified as most in-need, including zip codes with the majority of residents who are Latino, Spanish-speaking individuals, and Latino adults and older adults.

To assist in developing a strong application, the following documents can be referenced on the Monterey County Behavioral Health MHSA webpage (http://www.co.monterey.ca.us/government/departments-a-h/health/behavioral-health/mental-health-services-act):

- Scoring criteria
- Monterey County Behavioral Health Bureau Health Equity Report FY17/18
- Innovation Plan: Micro-Innovation Grant Activities to Increase Latino Engagement

Successful applicants will be contacted by MCBH and scheduled to meet with the Micro-Innovation Grant Review Board to refine project details as needed, prior to approval of funding.

The current deadline for submitting applications is April 15, 2019. Applications received after this date may be considered for the next application period to be held in Fall 2019.

Questions may be sent to MHSAinnovation@co.monterey.ca.us

1. Contact Information

Name:_____ Phone Number:_____

E-mail Address:_____

2. Population of Interest

a. Who do you plan to serve? (i.e., specific Latino/Hispanic ethnicity, language, culture, neighborhood, etc.)

_____
_____
_____
_____
_____

b. What issue do you hope to address?

_____
_____
_____
_____
_____

c. How many individuals to you expect to serve?

_____
_____
_____

3. Project Methodology

d. What idea do you want to test?

_____
_____
_____
_____
_____

e. How will you do this? (i.e., what work will be involved, who will do it, where and when will it happen, etc.)

4. Evaluation

f. What would it look like if your project was successful? How will you know?

5. Budget

Please list the costs and explanation of costs associated with this project:

	Cost ($)	Explanation of Costs
Estimated Labor Costs		
Estimated Materials Costs		
Other costs		
Total Request		

6. Timeline

g. What is the timeline for carrying out this project?

_____
_____
_____
_____
_____

Micro-Innovation Application Scoring Criteria

Does the application identify a unique and underserved Hispanic/Latino target population to be served by the micro-innovation activity?
1 – Target population is described in broad terms (no specific features related to ethnicity, language, region of residence, etc.; e.g., only "Latinos in Monterey County")
3 – Target population is identified by unique characteristics (one or more characteristics are identified, e.g., "Mono-lingual Spanish speakers", "Oaxacan farmworker communities", "LGTBQ Latinos in Salinas", etc.)
5 – Target Population is identified by unique characteristics, and it is apparent this population is not or cannot be adequately served by existing mental health services in Monterey County (supporting research is provided)

Does the application clearly identify a barrier to accessing care, that is unique to the identified target population?
0 – Barrier to accessing care is not unique to Hispanic/Latino populations.
1 – Barrier to accessing care is unique to language / communication challenges (i.e., This barrier is easily overcome by translating materials)
3 – Barrier to accessing care is unique to ethnicity, cultural history and/or trauma, geographic region in Monterey County, or another specific characteristic. It is unclear if, currently, the local mental health services system has no solutions to the identified barrier.
5 – Barrier to accessing care is unique to ethnicity, cultural history and/or trauma, geographic region in Monterey County, or another specific characteristic. It is clear that, currently, the local mental health services system has no solutions to the identified barrier.

Is the proposed solution offered through the micro-innovation unique and innovative?
Note: when using the word 'solution', this is in reference to solving the stated barrier to accessing care for the target population. As these micro-innovations are a form of pilot or research project, the 'solution' is the intervention being delivered to the target population through some product/service treatment.
0 – The application presents a solution that is not unique and innovative (e.g., "to hire more Spanish-speaking therapists", providing group therapy or informational sessions, media outreach such radio commercials)
1 – The application presents a solution that is innovative for Monterey County (i.e., it is clear the proposed solution is not currently being offered anywhere in Monterey County.
3 – The application presents a solution that is unique and innovative for the community at-large, where it is apparent that the proposed product/service has never been tried before.
5 – The application presents a solution that is unique and innovative, and is specific to engaging, connecting, and motivating clearly defined underserved population(s).

Does the project have a clear strategy to engage/connect with its target population?

0 – No, it is unclear how the target population will be reached and/or engaged to participate.
3 – Yes, it is clear how the target population will be reached and/or encouraged to participate.
5 – Yes, it is clear how the target population will be reached and/or encouraged to participate. Additionally, the proposed project can be safely implemented during the current COVID-19 pandemic (e.g., a plan for socially distanced activities is provided, or the project can be implemented virtually).

Does the application have a clear plan for providing and monitoring referrals to mental health services?
0 – The proposal does not include a clear strategy or plan that describes how the 2 following evaluation elements will be recorded: 1) The number of mental health service referrals generated by the micro innovation, and 2) the number of individuals that accessed care (i.e., followed up on a referral) as a result of this micro-innovation.
5 – The proposal does include a clear strategy or plan that describes how the 2 following evaluation elements will be recorded: 1) The number of mental health service referrals generated by the micro innovation, and 2) the number of individuals that accessed care (i.e., followed up on a referral) as a result of this micro-innovation.

Does it appear, through the project description and proposed timeline, that impacts of this micro-innovation (i.e., individuals accessing services) can be observed within 12 months of the start-date?
0 – No
3 – Yes

Are the costs included in the proposed budget justified?
0 – No
3 – Yes

Applications will not be considered if they score any 0 items, if unamenable. Competitive ranking for all scoring applications.

Appendix B. Referral Form

Client Name: _____

Contact Information:
_____

Date of Referral: _____

Please list name of agency/programs referred to: *(if more than one, list all)*	**Did this person participate at least once in the services of the agency/program that you referred them to?** *(mark 'X' on applicable response)*		
	Yes	**No**	**Unable to Determine**
1.			
2.			
3.			
4.			
What racial/ethnic categories do they identify with?:	○ American Indian or Alaska Native ○ Asian ○ Black or African American ○ Hispanic or Latino ○ Native Hawaiian or Pacific Islander Native Hawaiian or Pacific Islander ○ White ○ Multiracial ○ Another race/ethnicity: _____		
What language do you speak at home?:	○ English ○ Spanish Another language: _____		

Tear off below line for client:

Behavioral Health Resource Referrals

Agency/Program	Contact Information

Appendix C: Project Descriptions (Unedited)

Completed Project Descriptions (Unedited)

Round 4

Michael Houston/Greenfield Cultural Arts Events Outreach

Population of Focus

U.S. Census data indicates that 19.24% of families and individuals in South County and Greenfield are below the poverty line and struggling to attain self-sufficiency. Social and economic inequalities in culturally and linguistically diverse Hispanic/Latinx and indigenous communities in Greenfield and South Monterey are manifest in many ways. Income insecurity causes stress that impacts physical and mental health yet that community receives proportionately less mental health services than other demographic groups in the county. As we build healthier communities we need to mitigate poverty and health issues. Solutions are complicated by language and cultural factors. MCBH has indicated that communications for available services are not resonating with Hispanic/Latinx ethnicities and language groups in Greenfield and South Monterey County. In FY2016/17, Latinos made up 75% of the Medi-Cal eligible population in Monterey County, yet were only 53% of MCBH mental health service consumers.

The solutions begin at the community level to strengthen the connections between the community and health and social service providers. We propose engaging underserved families and individuals in Greenfield through arts programs that stress the value of accessing mental health services.

The program raises community consciousness to take positive ongoing action for positive mental health service outcomes among low-literacy, monolingual, bilingual, and multilingual farmworker families across generational lines. Program performances will be developmentally and culturally appropriate for every age group. The artist participants will be a sustainable culturally competent cadre for years to come.

Problem to be addressed

In the Greenfield community, there is a shortfall in predictable mental health services. There is a cultural disconnect between the community and the service providers. We need a micro innovation of consciousness-raising arts program led by artists from the Greenfield community to make the case for accessing mental heal services in Latinx Spanish, Indigenous, and bilingual populations. Artists from the Greenfield community need to act as a bridge between individuals and families and mental health services. Artists from Greenfield's agricultural and marginalized Latino/Hispanic community can connect more with Spanish and Oaxacan language, speaking. The Greenfield community has a rich artistic tradition in which children are raised in a tradition of dance, music, and spoken word arts. Well-attended events like the Fourth of July, Harvest Fest, Día de los Muertos, and Las Posadas document the diverse community's willingness to participate in the arts. The Greenfield arts community can help the community connect to the caseworkers and mental health services. Community arts thrive in a community, which finds itself threatened by social forces that reject the community's culture. The community arts have an entry into the diverse community cultures that include, religious beliefs, curanderas, and folk tradition.

A culturally rich program of shared performances, food, and discussions can mitigate fear and stigma too often associated with mental health services. We offer a safe comfortable inclusive family environment to discuss the value of accessing mental health services in the context of a participatory community celebration.

In these celebrations of the arts and well-being members of the Latino/Hispanic community can go beyond seeing the mental health services for others and see when it benefits them. In relaxed frank discussions, these same people concede that financial stress, overcrowded housing, youth incarceration, school issues, medical expenses, fear of ICE, etc. impact their sense of happiness and well-being. Our community art-as-healing approach in ongoing arts programs in a non-mental health setting can improve trust in the mental health service delivery system.

Proposed Micro-Innovation Activity
Greenfield Arte y Bienestar 2021 is a community collaboration by relevant local Spanish speaking artists and cultural performing acting community trauma and resilience leaders. Over four weekends in October and November Greenfield Arte y Bienestar 2021 will put on a series of comidas y presentaciones, food and a show. The cultural programs will consist of four Oaxacan, Spanish, and English language performance art, dance, and music productions including meet the author events, peer-to-peer discussions, and delicious meals Mexican held at the Greenfield Art and Cultural Library and the Greenfield library. As we prepare for the performances we will also connect with the families of the two youth Greenfield dance troupes, Arcoiris Cultural, folklorico group, and Azomali Danza Azteca, Aztec dance.

The program will perform at community events with artists presenting their work to respectfully help Latinos overcome denial and pride that could prevent them from addressing their wellness needs.

The two authors' readings at the Greenfield Library and tabling at community events will include book raffles and giveaways by local Greenfield connected authors with personal experiences of the benefits of mental health services when going through personal and family crises.

Performances and reading will be followed by an informal discussion and high-quality culturally appropriate meals. All activities will conform with the city, county, and state Covid 19 health guidelines.

The presentations will be videoed for presentation on public access television and web sites. The videos will be a long-haul help to educate Spanish and Oaxacan language viewers in Monterey County to understand the importance of finding the health services they need to achieve physical and mental wellness.

Communication and Engagement Strategy
Shared food and cultural meaningful arts experiences can bring people together. Culturally relevant community artists and performing groups with deep roots in the agricultural community can connect members of the Latino/Hispanic community of Greenfield. They can share personal experiences that validate the value of mental health services. They make the case that art improves the quality of one’s life and helps heal. Art teaches us discipline which teaches us new ways of seeing. Community artists can use their own experience to explain that Spanish speaking caseworkers in Behavior Health help heal. In an unthreatening, our performing artist shares good culturally appropriate food and a good show with the community. They are promotores of well-being who share their art and stories with appropriate literacy leveled materials. They create situations of meaningful communication to promote the acceptance of formal and informal neighborhood, city, county, and state services. The positive artistic consciousness-raising process promotes better communication and collaboration between agencies/organizations and the community.

Our innovative mini-project Greenfield Arte y Bienestar 2021 is designed to meet the mental health access needs of the Spanish Speaking Salinas Valley community.

Evaluation Plan
Low-literacy surveys will identify how many Latino individuals that have never engaged with mental health services received a referral for mental health treatment services. Surveys will identify how many Latino individuals followed through on a referral and received mental health treatment services. Surveys to count of Latinos served increased during this Innovation project. Ongoing surveys will identify language preference - Spanish, triqui, mixteca, English).

Surveys ask participants about their sense of well being, possible likely of getting help for a friend, relative of services in Spanish, After how would you help a friend you thought might need emotional support Greenfield Arte y Bienestar 2021 will demonstrate its success by the number of participants who become applicants for Spanish-speaking program manager service and referrals for mental health services.

How many individuals do you plan to serve or reach with your micro-innovation activity?
600

How many individuals do you plan to refer to mental health services?
300

Door to Hope/'Circle of Security' Program for Farmworkers
Population of Focus
Door to Hope (DTH) will increase access to mental health services to a vulnerable population within Monterey County by adapting the evidenced-based practice Circle of Security (COS) to better serve underserved and unserved migrant farmworkers and Indigenous communities. Through the Micro-Innovations grant, DTH will assist in breaking the barriers and challenges Non-English-speaking individuals face in Seaside, Jolon, Greenfield, King City, San Ardo, San Lucas, San Miguel, Lockwood and Bradley. DTH has formed trusting relationships within these communities and has adapted to their needs offering documents, materials, activities and the sharing of information in Spanish, Triqui, and English.

Immigrants comprise over 30% of the total population in Monterey County and many families within this community have relocated from Mexico. They are experiencing mental health problems, trauma related issues, and continue to face daily challenges. Migrant farmworkers and indigenous communities experience physical stress at work, coupled with mental stress from family separation, documentation status concerns, and insecurity of work opportunities. As a result of poor wages, farmworkers routinely struggle against poverty and, because of their mobility and often due to language and cultural differences, they often feel a lack community support. Trauma endured before, during, and after migration, the struggles with behavioral and mental health concerns including post-traumatic stress disorder (PTSD), anxiety, stress, depression, substance abuse, and/or suicidal ideations pose an immediate threat to their mental health. It is important to consider the unique challenges and lifestyles of this population when it comes to their care, including how we address their mental health needs.

Problem to be addressed
DTH has the mission and the motivational capacity to break the barriers and challenges migrant farmworkers and indigenous communities face seeking mental health services. Trust, shame, and cultural taboos compound the language, transportation, employer-related scheduling conflicts, financial and affordability restraints. Families feeling unwelcomed and excluded, treated without respect or concern and the perception that undocumented members of the community are excluded from services are major challenges. Monterey County has the highest percentage of non-citizens of any California

County. These are some of the many barriers and challenges preventing underserved and unserved communities from accessing mental health services.

The majority population being Hispanic/Latino, Spanish is the most common language spoken at home (47% of the households in Monterey County). However, many from the indigenous communities speak neither English nor Spanish. Information and technology challenges within these communities are apparent and DTH continues to bridge this gap with bi-lingual and tri-lingual staff and open office hours at the Greenfield Community Center. DTH assists community members with documents, technology, translation services, and referrals to community agencies.

Mental illness within the community is highly stigmatized and keeps families and individuals silent. Men, women and children are reluctant to speak about mental health issues they may be experiencing. The fear of emotional concerns being dismissed, the stigma around mental health, and the fears of mental health issues being discussed outside the home weigh heavily on families and individuals. The reluctance to reach out for mental health services is often out of fear of the unknown. Providing access to early intervention services such as Circle of Security will build awareness, trust and confidence within these communities. Creating culturally sensitive spaces will allow parents to begin exploring what mental health means to them and for some this will lead to referrals in mental health services for more specialized support. Bi-or-tri-lingual Circle of Security Care Coordinators will reduce the disparities in order to build the relationships within the community and will result in increased identification and mental health service delivery.

Proposed Micro-Innovation Activity
1. What product/service is your micro-innovation providing to this population of focus to address the barrier(s) described above?

With the Micro-Innovations grant DTH will adapt and provide the Circle of Security (COS), engagement, and case management activities in Spanish and Triqui to the underserved and unserved Migrant farmworkers and Indigenous communities in Seaside, Jolon, Greenfield, King City, San Ardo, San Lucas, San Miguel, Lockwood and Bradley.

COS is an internationally recognized intervention/prevention program for parents. The COS program has aimed to promote secure child-parent attachment relationships. Its main goal is to translate decades of university-based attachment research into a user-friendly format for parents to learn how to provide both secure bases and safe havens for their children.

Program Summary
§ Provide outreach, engagement, and warm welcoming services through community stakeholder referrals.
§ The COS program is group-based: Parents will participate in 1½-hour group meetings once a week for 8 weeks with 15-20 other parents.
§ Week 1: Welcome to Circle of Security Parenting
§ Week 2: Exploring Our Children's Needs All the Way Around the Circle
§ Week 3: "Being 'With' on the Circle"
§ Week 4: Being with Infants on the Circle
§ Week 5: The Path to Security
§ Week 6: Exploring Our Struggles
§ Week 7: Rupture and Repair in Relationships
§ Week 8: Summary and Celebration

§ Provide case management services and referrals to improve individual and family functioning and mental health for participants in COS.

These sessions will be co-facilitated by members of the indigenous community for the indigenous community. Sessions will be tailored to meet the scheduling, language and cultural needs of these communities. Parents are invited to identify and reflect on the child's needs throughout each session surrounded by a supportive presence of fellow community members and DTH Care Coordinators. DTH's bi- and tri-lingual capacity will expand understanding to the indigenous-speaking communities. Videos in Spanish will be used extensively to promote parental reflection on parent/child interactions. Once mental health concerns are identified our COS Care Coordinators will guide families through the referral process and through individualized case management services we will assure families are connected to the resources they need to continue exploring their mental health needs.

The overall goals of COS:
• Increase security of attachment of the child to the parent.
• Increase parent's ability to read child's cues.
• Increase empathy in the parent for the child.
• Decrease negative attributions of the parent regarding the child's motivations.
• Increase parent's capacity to self-reflect.
• Increase parent's capacity to pause, reflect, and chose security-promoting caregiving behaviors.
• Increase parent's capacity to regulate stressful emotional states.
• Increase parent's ability to recognize ruptures in the relationship and facilitate repairs.
• Increase parent's capacity to provide comfort when their child is in distress.

COS educates, supports, and treats communication, stress, and emotional issues in families. The engagement process builds relationships. Case management and care coordination promotes successful outcomes for these parents and their children. This micro-innovation project will allow for the development of a trusting relationship to be built to engage an isolated and underserved population in their own language to improve bonding and attachment in their family.

2. How will your product/service promote this population of focus to seek mental health services when the need for mental health services has been identified?

Adapting COS and expanding access to Non-English-speaking individuals within the migrant farmworkers and Indigenous communities in Seaside and South County will promote fundamental improvements to the population of focus to seek mental health services. The relationship between child and caregiver has a significant impact on attachment and ongoing connection. Parents that have experienced complex trauma and live with mental health issues may struggle with attachment and emotional regulation. By supporting this group of parents in a way that helps them understand the role of attachment and how they can form positive relationships with their own children we can significantly build trust and confidence to improve both child and parent outcomes. DTH Care Coordinators will work diligently to build and gain the trust through meaningful conversations introducing Monterey County's mental health services to the migrant farmworkers and indigenous populations.

In order to succeed in connecting the migrant farmworkers and Indigenous communities with mental health services Comprehensive Case Management (CCM) must be provided. Case management is "a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive needs." DTH's case management is a coordinated approach to the delivery of health, behavioral health, and social services, linking clients and families with appropriate services to address specific discerned needs and promote

meeting identified goals and outcomes. This approach lends itself to gaining access to meet the needs of clients and families with multiple conditions and disorders who face difficulty in gaining access to services. COS will serve as the skill group and Comprehensive Case Management will engage, build trust, and help this community gain access to other mental health services in Monterey County.

3. How is this innovative? Please describe how your project is innovative. For purposes of this application, the term "innovative" includes, but is not limited to: the proposed work to engage the target populations has not been done in Monterey County before; the proposed project presents an entirely new practice or approach, or an adaptation of a successful practice or approach from a non-mental health setting, to improve access to mental health service; the proposed project is unique. Please provide supporting evidence to demonstrate the uniqueness of your proposed project, i.e. nothing like it currently exists in Monterey County.

This project is an adaption of successful evidence-based practices, i.e. Circle of Security and Comprehensive Case Management, with a new, un-studied, and difficult population. The integration of these practices delivers mental health services in an acceptable and allowable manner to a resistant group with language and cultural barriers. This is a unique opportunity that does not currently exist in Monterey County.

Communication and Engagement Strategy
1. How will you reach and interact with your identified population of focus to deliver the product/service(s) of your micro-innovation activity?

DTH has developed a collaborative relationship with aspects of this target population particularly through contracted services with South County schools, family resource centers, and other community providers and stakeholders. We provide parent education and play groups through contracts with First 5 Monterey County for families with young children ages 0 to 5 years old. We have excellent outreach and engagement strategies with the targeted population and community. We currently provide:
• Parent education services
• 15 playgroups each week in South County
• Serve over 100 families in target population
• Tri-lingual English, Spanish, and Triqui capacity.

DTH now wishes expand and enlarge our capacity within the migrant farmworkers and Indigenous communities to families with school aged and adolescent children at-risk for mental health problems. DTH has the bi-lingual and tri-lingual capability amongst culturally congruent selected staff members. These staff are already known and trusted in this community. DTH currently has the capability of providing COS in Salinas, Greenfield, King City and Seaside. In addition, DTH Care Coordinators can schedule home visitation, telephone and virtual platform appointments.

DTH's goals and objectives if awarded the micro-innovation grant are:
§ Expand its staff who are trained in COS and CCM to include those who speak Triqui,
§ Facilitate fidelity to the evidence-based practices,
§ Outreach to families with not only pre-school young children, but school-aged children and teenagers,
§ Provide COS skill groups,
§ Provide care management and coordination to increase accessibility for other appropriate mental health services in the family.

2. If your activity involves in-person contact, please describe how you will take precautions against the spread of COVID-19 and observe current Shelter-in-Place restrictions.

DTH is continuously monitoring and responding to the evolving situation around COVID-19, including taking special precautions to ensure the safety of clients and staff. Door to Hope has completed a detailed risk assessment, modified its facilities, and changed its practices to meet CDC guidelines and the current California Shelter-in-Place requirements for Monterey County. We have and will remain operational during this time with some modifications to the services we provide. Our staff has worked tirelessly connecting families to current virtual platforms and has had proven success. We are currently providing services to 170 families virtually in individual home sessions and play groups. We have completed 3 COS series, with 1 series of 8 in-person and 2 series of 8 virtually. We had great attendance in all that we offered. Due to current Shelter-in-Place restrictions COS will be offered on a virtual platform and as State and County guidelines allow, DTH will provide in-person sessions as well. We can offer in-person sessions in our accessible and convenient locations in Salinas, Greenfield, and King City.

Evaluation Plan
1. How will your micro-innovation activity provide individuals with information and referrals to obtain a clinical appointment? Who, as part of your project, will be responsible monitoring the number of referrals that are provided?

DTH Care Coordinators will provide participants of the COS sessions with information about mental health services. When needs for further mental health support are identified, our Care Coordinators will provide comprehensive case management services to assure families are connected and receive services. Each Care Coordinator will be responsible for monitoring the number of families served and the number of referrals provided.

2. How will you gather information from referred individuals to know if they were able to access/attend at least one appointment?

Each case that is referred to additional mental health services will be tracked until the outcome is reached. Care Coordinators will reach out to families routinely to gather information and provide support connecting with services if needed.

3. In addition to MCBH, will your micro-innovation provide referrals to other agencies for mental health services? If so, please specify.

Door To Hope has extensive experience and relationships with many of our county's mental health services. In addition to MCBH we can also refer families to our own ICT and MSTART programs as well as Harmony at Home, Community Human Services, PVPSA, Seneca Family of Agencies, Interim Inc., Sun Street Centers, Monterey County Probation Child Advocacy Program, Bienstar, and Centro Binational para el Desarrola Indigena.

How many individuals to you plan to serve or reach with your micro-innovation activity?
50 (enrolled into COS)

How many individuals do you plan to refer to mental health services?
25 (of COS participant to referred to MCBH/additional Mental Health services)

MILPA/Rancho Cielo Youth Leadership Training
Population of Focus
MILPA will focus on serving and engaging system impacted youth (particularly Latinx) who attend Rancho Cielo Youth Campus who are suffering from trauma, systemic racism, and chronic adversity and

historically have decreased access to mental health services. Rancho Cielo is a comprehensive learning and social services center for underserved youth in Monterey County and focuses on youth that have been impacted by the juvenile justice system and is currently or formerly on probation.

Problem to be addressed
System impacted youth in Monterey County are lacking access to appropriate social and emotional cultural mental health services. They are often exposed to community violence, lack positive adult role models and mentors, which in turn leave them prone to negative peer pressure, engaging in high-risk behavior. These services would address the chronic adversity, intergenerational trauma, and community violence caused by a host of racial inequities, white dominant paradigms, and systemic injustices that too often marginalize them based upon their race, class, and/or gender.

Proposed Micro-Innovation Activity
1. MILPA is proposing to provide culturally relevant mental health support and practices to system impacted youth under the Telpochcalli umbrella. Telpochcalli is a healthy and transformative space for youth. It was designed as a positive social outlet where youth can network with other youth while discussing topics related to racial inequity, civic responsibility and their overall well-being.

The Telpochcalli approach is a micro-innovation and supplementary practicum to the evidenced based curriculum of the Joven Noble and Xinachtli programs which often are implicit versus explicit when considering the impact of colonization, assimilation and acculturation related stress. However, due to the success and evidence of both the Joven Noble and Xinachtli we will be conducting them virtually at Rancho Cielo.

The core concepts and story science behind the Telpochcalli will increase the awareness, communication skills and provide them the ability to develop positive narratives about their community while exploring the social determinants of health. A critical element of Telpochcalli is to foster the critical consciousness learning around the racial inequities that are present in their day-to-day lives. Through this umbrella, youth are empowered to analyze the world around them, think critically about both problems and solutions, and create an action plan that fosters health for themselves, their families, and community. Joven Noble (Noble Youth) is a 10 week “rites of passage” curriculum which is culturally based and geared towards teen boys. Youth will develop leadership while addressing trauma, positive cultural identity, and how to develop strong self-esteem, in a safe and healthy mental space. Joven Noble is an evidence based program according to the Substance Abuse and Mental Health Services Administration (SAMHSA). Xinachtli is a12 week “rites of passage” curriculum which is a culturally competent bicultural youth character development process designed to provide teen girls the guidance and tools for self-confidence, resilience and leadership for a healthy development into adulthood.

2. In the structured virtual setting, Telpochalli will intake referrals, implement services, and refer participants to mental health services with MCBH. Telpochalli will bring forth an adaptation of a successful practice and approach from a non-traditional mental health setting, to improve and encourage access to mental health services. By fostering intergenerational mentorship with the staff of MILPA, youth will gain character development, social emotional wellness and mental health awareness. A highlight is that the youth themselves engage in a safe space and navigate peer to peer relationships in a prosocial way embraces the opportunity for self care and want to seek services.

3. The proposed MILPA innovation pulls from indigenious based practices, story-telling and from elders, who are often disregarded in our western modernized society. In addition, Telpochalli addresses the target population of Latinx communities as listed in MCBH Health and Equity report and applies a promising community-driven approach that has been successful in non-mental health context or setting

to the mental health system. MILPA is derived from the Uto-Aztecan Nahuatl word “Milli” that translates to mean "field" and is used as a proxy for the Tres Hermanas agricultural philosophy of planting beans, corn and squash and is reflective of village and relational values found in cultures throughout the world. As such the Tres Hermanas is an ancient tradition of working together in the community to achieve abundance, reciprocity, and sustainability. Applying cultural and inter-generational mental health services to our underrepresented and marginalized Latinx communities will create institutional change in mental health awareness. MILPA programming is innovative and holds promise to engage with these communities, examine how they are underrepresented, underfunded, and marginalized by institutions of power.

Communication and Engagement Strategy
1. In partnership with Rancho Cielo, MILPA will work with academic staff to identify populations of focus for MCBH that are currently enrolled in Rancho Cielo and that would benefit from MILPA services. We will use interactive and engagement software such as Zoom and Kahoot, to utilize technology and bring digital innovation. 2. Due to COVID-19, we plan to provide our services virtually, with the goal of working converting to in-person when Conditions change and we get guidance from health officials.

Evaluation Plan
1. We will work with MILPA’s and Rancho Cielo’s Therapist/Social Worker staff to develop and implement intake forms that will be collected from all youth participating in our programs. Demographics will be a part of the intake questionnaire along with asking if any participants have been referred to MCBH in the past. Program facilitators and internal data collectors will be monitoring all data and referrals. MILPA will also be collecting pre and post survey evaluations per program to review the impact on each participant.

2. If a participant is referred to MCBH, we will document the referral and send a copy to MCBH. We will also apply a follow up with that participant being referred to check on progress of receiving mental health and require to have their referral signed off by a MCBH official. Our goal would be to work with MCBH to ensure a harm handoff happens and the Individual receives the correct services. 3. MILPA strongly believes in the use of indigenous and culturally rooted practices that provide respite for healing and overall well-being. If any participant requests a referral to this approach, MILPA will refer participants as well to MCBH services as well indigenous elders.

How many individuals to you plan to serve or reach with your micro-innovation activity? 100

How many individuals do you plan to refer to mental health services? 20

Emeralda Owen/Public Service Announcements
Population of Focus
This is a MEDIA AND MARKETING INNOVATION IDEA to help disseminate information about mental health services in Monterey County to the Latino population. Most of the first and second generation Latinos who live in the County are of Mexican descent and speak Spanish. Some come from regions in Mexico that speak in dialects (Mixteco, Zapoteco, Triqui). This plan will cross over County lines into San Benito, Santa Cruz, and a bit of South Santa Clara Counties because of the nature in tools to be used to spread the information (TV/Radio/Social). For Monterey County, the focus will be the 101 HWY corridor which expands over 100 miles from Prunedale, Salinas, to South of King City. Other cities that will benefit are Seaside, Marina, Castroville, which house a great number of Latino families. I have a list of radio stations in our area who will (confirmed) provide free air time to talk about services in the area in short and long segments. I would consult with you first to make sure the correct information is

disseminated. In addition, a page on your website or phone number is recommended in order for the community to know where to start.

Problem to be addressed

In the Latin American culture, in general, mental health services are avoided at the fear of being labeled as insane, retarded or weak-minded. This is a stigma that stems from an early age where bullying among siblings, family members, or even classmates may play a role in how insecure individuals feel about this topic. The reason Latinos don't seek mental health services is mostly cultural, but these can be molded or adjusted with good information from trusted sources. Nowadays, more layers of trauma have been added to the already vulnerable communities. The Coronavirus, social and political unrest, etc. are creating even more anxiety in Latino youth and adults. A lot of Latinos in our communities face a lot of challenges each day, especially if they are undocumented or live in poverty or both. Gangs and drugs are infiltrating themselves into families creating destruction that cannot be repaired because help is avoided. Monterey County faces a lot of uncertainties for Latinos who deep inside, wish to do their best but are labeled even before they speak or do anything. This is not a good way to live. But even though Latinos are facing all these challenges, day in and day out, they are too proud to seek help.

Proposed Micro-Innovation Activity

My idea is to propose a MEDIA AND MARKETING INNOVATION PLAN. Being a journalist and an expert in marketing places me in a position of creativity and accessibility. I have contacts in the region that will provide me with air time to get the information broadly shared. With this plan, I will create 10-11 PSAs in Spanish for Television and Radio, plus translate them into the dialects mentioned for radio and social media dissemination. I plan to ask local Latino leaders in the community to be the face in some of the commercials to create relevance and familiarity. But I also feel it would be prudent to ask real members of the community struggling with any type of mental health issue. I will use my media expertise to place the PSAs in all Spanish speaking media in the Central Coast and seek opportunities with organizations that want to feature the PSAs on their websites or social media. If this proposal is accepted, the first month would be about the production of the 12-month plan, which would include the production of the first PSA. I will call in key individuals in the community and experts in mental health services to be a part of an advisory committee that will help me stay on track and to monitor, evaluate, and adjust the plan.

Along with the PSA and media outreach, I will design a pocket-size, quadfold document with resources for mental health services in the County. These will be delivered to homes with the use of volunteers and in targeted areas in South County, Salinas, and delivered to school parent coordinators, key programs and organizations in the community, etc. If the quadfold document idea is not suitable due to covid-19, I would love to offer a mini-conference to be delivered via Zoom and have experts in mental health present and answer questions. This can be something that can be offered at mid-point and make sure that the community is aware of it. I will make myself available and when possible have an expert with me for media interviews, shows, radio interviews, etc. In addition, I have found my press releases to be effective. The media loves information that is already written and I know exactly what they want and how they want it in order to be assured that the story or information will appear in the evening news that day.

Communication and Engagement Strategy

Most of the work will be crafted by me. As you can tell, I have already spent time designing the concept I am proposing. I would be able to execute the plan immediately upon approval. All the production of PSAs, marketing materials for social media, press releases, quadfold, etc. will be under my creative control. I will, however, need the help of a television production company for the creation of the PSAs, a graphic designer to create the quadfold (or magnet) and other relevant graphic designs, translators, do a call for volunteers, hire one or two interns. This is a project that will span through all 12 months and will

require constant follow up and follow through. I will develop a small advisory committee to help keep track of the project and provide extra resources or contacts I may need. Depending on how the advisory committee feels, we will meet monthly or bimonthly.

Evaluation Plan
The evaluation can take place on a monthly basis. I will use analytics, number of clicks on website, number of calls, number of likes on social media, and create a survey at midpoint and at the end of the campaign to evaluate and compare.

How many individuals to you plan to serve or reach with your micro-innovation activity? 40000

How many individuals do you plan to refer to mental health services? 5000

Round 5

Monterey County Public Health Bureau

Population of Focus

Monterey County Health Department's Chronic Disease and Injury Prevention Division currently serves Alisal and Everett Alvarez High Schools in the Salinas Union High School District (SUHSD) by providing training, education and resources in health education through Postpone (a teen pregnancy prevention program) to all incoming freshmen at Alisal High, and students taking health at Everett Alvarez High, by way of peer education and fotonovela (a storytelling tool to engage youth in learning about issues such as health and other adult preparation topics). Postpone has been implemented in our community for over 25 years.

While our current work provides youth with information and education related to their physical development, sexual and reproductive health, and other adult preparation areas, there is a gap. Our program does not currently address youth's mental health needs. Postpone facilitators agree that trauma, depression, and anxiety are among the mental health issues that are commonly observed in our program participants and are sometimes disclosed by the students themselves to our peer educators with whom they've built trust and rapport. These issues are often associated with adverse childhood experiences (ACEs), poverty, homelessness, violence, stress associated with being undocumented or being in a family with mixed documentation status, and family dynamics.

We propose to expand our work to address youth mental health needs by providing mental health education directly to youth and by making and tracking our referrals to Behavioral Health. Our project will focus on youth at the two high schools that we currently serve: Alisal and Everett Alvarez High Schools. According to Ed-data.org, during 2019 there were 2,988 students enrolled at Alisal High School and 2,306 students enrolled at Everett Alvarez. Our goal is to train a minimum total of 30 peer educators through implementation of the Mind Matters curriculum, a minimum of one public health student intern, and reach a total of 1,000 students from Everett Alvarez and Alisal through classroom presentations. We will train peer educators to complete one-on-one outreach to their peers, document their interactions, and post positive messages about accessing mental health services on their social media in an effort to reduce stigma and increase the understanding of mental health resources and services.

The schools' students are our proposed focus population and include a significant number of students who face language barriers in accessing County services. More than 25% of Monterey County's 434,000 residents do not speak English; approximately 100,000 speak only Spanish. In 2019-2020, approximately 88% of students at Alisal High School and 78% at Alvarez were a combination of English learners, foster

youth, or eligible for free/reduced-price meals. Both schools serve speakers of languages beyond Spanish, such as Tagalog, Korean, and many indigenous languages including Triqui, Mixtec, Zapotec, and Nahuatl.

In the city of Salinas, where both Alisal and Everett Alvarez High Schools are located, a Latinx family is three times more likely to live below the poverty level compared to a White, non-Hispanic family (2019 ACS, 1-Year Estimates US Census Bureau). The Centers for Disease Control and Prevention noted in a 2016 report (Vaughn, M.G., Salas-Wright, C.P. & Maynard, B.R. J Public Health (2014) 22: 265) that one important strategy to prevent and reduce health disparities is increased education in general, including high school completion. This proposal aligns with this strategy to support reducing health disparities and addresses some of the barriers to high school completion, such as teen pregnancy and unmet mental health needs. This project will also build on the success of the Postpone program in reaching and engaging youth to provide outreach, information, and referrals for youth.

Problem to be addressed

In addition to the language barriers described above, many of the youth that Postpone serves do not seek mental health services because they are often faced with immigration-related stress, reluctance to seek help due to stigma, lack of understanding by family and friends and/or not knowing where to turn for help. The peer education model is a health promotion method where students receive medically accurate information and resources from their peers. Often teens go to other teens to get help for things such as reproductive health, homework, where to find a job, etc. Having other teens come into their classroom to speak on topics such as depression, anxiety and mental health in general can help normalize mental health services and increase the likelihood that the youth in the classroom will seek help and not internalize stigma.

Prior to COVID-19, students were already struggling with mental health issues. According to Kidsdata.org in 2017-2019, in Monterey County, 28.6% of 9th graders stated they experienced feelings of depression. Why does this matter? Kidsdata.org states that mental disorders affect as many as one in five U.S. children each year and are some of the costliest conditions to treat—mental health problems among young people under age 24 cost the U.S. an estimated $247 billion annually. Unfortunately, many young people who need mental health treatment do not receive it, and mental health problems in childhood often have negative effects in adulthood.

By training the Postpone peer educators and at least one intern in the Mind Matters curriculum, at-risk youth will be given tools to seek help and address some of the mental health issues they might be experiencing. The peer educators will take what they learned from the Mind Matters curriculum and provide classroom outreach/presentations using the skills learned in Mind Matters. By having the peer educators present in the classroom and serve as liaisons of mental health, we will increase the number of young people who are likely to get these much-needed services in our community. Postpone peer educators will recruit students into mental health services provided by Monterey County Behavioral Health and other community partners such as Harmony at Home. The student intern will support referral follow ups.

Proposed Micro-Innovation Activity

To address the described barriers, the Postpone program will purchase from The Dibble Institute the evidence-based Mind Matters curriculum and training. Mind Matters is intended to help youth overcome adversity and build resilience. Mind Matters has been used to prevent violence, address chronic absenteeism, and build a culture of wellness. The Dibble Institute provides the following description of this course:

Mind Matters' practical, hands-on lessons explore the effects of adversity and toxic stress along with the healing process. Each lesson, based on ACEs science, includes activities on increasing hope, overcoming adversity, and building resilience.
The lessons address the following topics:

- Self-Soothing and Regulating Emotions: Cultivate a mindfulness practice
- Managing Stress Effectively: Learn to reduce intrusive thoughts
- Developing Empathy: Improve interpersonal communications
- Creating a Code of Honor: Develop a life of intention
- Building and Using a Support System: Learn how to ask for help

Postpone peer educators and a student intern, under the guidance of a public health coordinator, are a natural fit to learn this curriculum and apply the learned skills to their outreach and presentations. The skills taught in Mind Matters are designed to be practiced over a lifetime. The curriculum does not replace therapy. When the skills learned by peer educators are modeled to and shared with students, the curriculum will inspire, uplift, and build resilience of other youth.

Peer educators will present and promote program material to all the freshmen at Alisal High School during the Advancement Via Individual Determination (AVID) program. The AVID program is a nationally recognized program that prepares students, who are academically in the middle, for four-year college eligibility. Peer educators will also present at all health classes at Everett Alvarez High School. Educators will reach an unduplicated 1,000 youth through classroom presentations. This will be documented via sign-in sheets with student demographics. A post- evaluation survey will also be collected from each student and the knowledge attained will be documented onto an Excel form.

During the spring, a second training will be conducted for peer educators on the topics of the Mind Matters curriculum, sexually transmitted infections, human trafficking, and community resources. The presentations will be then conducted again in the AVID classroom, and health classes. The students who receive the fall presentation will receive a second presentation in the spring. The presentations will offer students an opportunity to ask questions and to be referred to the community resources that fit their needs. Just as in the fall, the spring presentations will be evaluated with sign-in sheets and a post survey with the new topics incorporated. As a result of our regular Postpone presentations, we see an increase in students accessing medical clinics for family planning, access, care and treatment (PACT). We anticipate the proposed and enhanced Postpone presentations with information on mental health needs and access will have the same results as we will be facilitating access to information and services.

The Mind Matters curriculum by the Dibble Institute will be implemented to all Postpone peer educators. Every effort will be made for educators to complete 100% of the training. However, if completion is not possible due to unplanned circumstances the educator must complete at least 75% of the training to continue as a peer educator. The information they learned will be shared with others via social media posts, and one-on-one conversations with students. These conversations will be documented on an outreach form and turned in monthly to the public health coordinator in return for a $20 gift card. The outreach forms will help us track the number of referrals and people contacted. Peer educators will also wear their Postpone T-shirts, a strategy we use to engage students. When wearing their Postpone T-shirts, educators will be regularly approached by students needing resources in the community. With support from Behavioral Health and the micro-innovation grant, we can create safer spaces for youth to receive information free of stigma.

Monterey County Public Health proposes an innovative project pairing our successful Postpone peer education program with an adaptation to include a focus on mental health services. Through Postpone, we will train and recruit high school students in Salinas, ages 13-18, to be part of the peer education

program. Peer educators will learn the standard Postpone topics in adult preparation, sexual and reproductive health, and with this grant will also learn to promote mental health and access to services. Peer educators will be trained to refer to Behavioral Health any youth who are in need of mental health services. For the past 25 years Postpone has given students the skills they need in adult preparation areas (e.g., advocating for themselves and others, learning public speaking skills) and becoming educated on important health topics. Peer educators have proven year after year that this model is effective in reaching other youth. Each year, Postpone meets or exceeds their reach goals of 1,000 students.

Postpone is open to all students enrolled at the targeted high schools, regardless of their grade point average and attendance. This ensures that Postpone is reaching youth from a variety of backgrounds and with varying needs. Postpone uses the Youth Development model: competence, confidence, connection, character, and caring/compassion. The Postpone program also functions as an official club at both schools and has a teacher as an advisor. The teacher/advisor serves as the liaison between the Monterey County Health Department and the school. Adding the Mind Matters curriculum, training our peer educators as facilitators in this new program area and teaching peer educators to identify the need for mental health services will be an adaptation from our current program. Postpone is a program of the Monterey County Health Department and as such there is not another program with this model in our County.

The schools will be open in the fall for student interaction; if another shelter in place order goes into effect, training and meetings will be held via Zoom. Classroom presentations can be scheduled via Google Meets at the high schools if necessary.

Although Postpone has been in existence for 25 years, its primary focus has always been on sex education. We plan to take this successful program, with our existing school and community contacts, and pivot the focus to mental health. In Monterey County we do not currently have a peer education program to promote mental health.

Communication and Engagement Strategy
The goal of Postpone is to improve the health of young people living in Salinas by focusing on health education, leadership, and advocacy. To accomplish this goal, the program works with community-based organizations, parents, teens, and schools. Public Health will reach and interact with our identified population of focus through Postpone.

We will train and recruit high school students in Salinas, ages 13-18, to be part of the peer education program. Peer educators will learn the standard Postpone topics in adult preparation, sexual and reproductive health, and with this grant they will also learn to promote mental health and access to services. Peer educators will be trained to refer to Behavioral Health youth in need of mental health services. Postpone provides students the skills they need in adult preparation areas such as advocating for themselves and others, learning public speaking skills, and becoming educated on important health topics.

At each one of the high schools we will train a minimum of 15 Postpone peer educators (a minimum of 30 total). Each peer educator will complete the Mind Matters curriculum from the Dibble Institute and will provide program information to fellow students via in person contacts and social media. Student interns in our teen pregnancy prevention program will also be trained in the Mind Matters curriculum and they will assist the Chronic Disease Prevention Coordinator with referral follow ups.

Recruitment of students for Postpone will occur at both schools. Each peer educator will fill out an application and a permission slip from their parent/guardian. The permission slips are important because students will be the liaison between County staff and other students on campus. The permission slips also serve to inform parents of the topics that will be covered. There will be two peer educator trainings at each school, one during the fall and one in the spring, for a total of 4 trainings.

The Mind Matters curriculum will not only assist our Postpone peer educators to clear away barriers to their own focus and learning but it will build skills in the peer educators that will transfer on through one on one interactions, presentations and other outreach strategies to the youth that they are working with. Peer educators will also learn to identify some of the signs which may indicate the need for mental health services such as declines in school performance, poor grades, constant anxiety, social withdrawal, or aggression.

Monterey County Health Department's priority is to always meet or exceed our annual reach goals. Prior to COVID-19, we had not experienced significant challenges in meeting our goals. However, the pandemic made it more difficult for us to reach youth. Our established relationship with schools and community members helped us to meet our reach numbers for fiscal years 2019/20, and 2020/21. Monterey County's shelter in place order has since been lifted. Should the County return to shelter in place restrictions, our program is prepared to return to offer activities through Zoom and other platforms as approved by the schools.

During the shelter in place orders, our program staff worked closely with teachers to record videos, pre-record sessions and to offer live implementation. The staff also trained on Microsoft Teams and Google Meets. Key to the success of our program is remaining in constant contact with school administrators. A close working relationship with administration at each site is required to build trust, schedule the program, meet student needs, and share community resources. Program staff meet with administrators to schedule implementation a few months in advance, and we discuss student expectations and site-specific programming.

For the upcoming school year school administrators have announced a requirement for students to come back to campus in person. Our program staff is prepared to serve students in person and/or virtually and will adhere to all State, County and school guidelines on social distancing and face covering requirements.

Evaluation Plan

Social media posts will be created to normalize mental health services, and peer educators will track the number of likes and reshares. Each student that attends the Postpone presentations will receive information about how to make clinical mental health appointments. When students ask for information from our peer educators, the educators will document the request on their contact sheet and ask permission for our intern to follow up with a referral to Behavioral Health (only phone numbers, age, and preferred name will be documented). If someone doesn't want to be contacted by our intern, we will ask the peer educators to follow up with them. Under the direction of the Health Program Coordinator, the program intern and/or Chronic Disease Prevention Coordinator will make weekly calls to new referrals to see if the students attended at least one of their BH appointments. We will also work with BH staff to create a referral code or other tracking method so that BH knows that students/ families referred came from our outreach efforts.

Under the direction of the Health Program Coordinator, the program intern and/or Chronic Disease Prevention Coordinator will make weekly calls to new referrals to see if the students attended at least one of their BH appointments, or if additional support is needed by the student to make a call or an

appointment. Logs/spreadsheets with non-identifying information will be maintained to track numbers and outcomes of referrals.

The Postpone program will add mental health services to their presentations, information will also be included on flyers and posted in the classrooms. Referral forms/discreet cards will be carried by all peer educators to refer students to services. Along with a contact log, educators will turn in referrals to the program coordinator or a program intern to forward to Behavioral Health. The program intern or program coordinator will follow up with referred students to ensure additional questions (if any) are answered or support is provided in making an appointment if needed. All students who are present during peer educator presentations will also receive a resource sheet of existing mental health services available in our county.

How many individuals to you plan to serve or reach with your micro-innovation activity? 1030

How many individuals do you plan to refer to mental health services? 103

Timeline
August 2021. Outreach to Peer Educators, recruit, distribute information, recruit minimum of 30 students, hire paid intern (if possible, Postpone alumna will be recruited for this position).

September 2021. Training #1 for peer educators, one at Alisal High, one at Everett Alvarez High, begin the Mind Matters curriculum, hold lunch meetings, begin to collect contact logs.

October/ November 2021. Begin Postpone presentations in classrooms, hold lunch meetings, collect contact logs, follow up on referrals.

December 2021. Hold lunch meetings, collect contact logs, follow up on referrals.

January 2022. Hold lunch meetings, collect contact logs, follow up on referrals.

February 2022. 2nd round of outreach for peer educators, distribute information, hold lunch meetings, collect contact logs, follow up on referrals.

March 2022. Training #2 for peer educators, one at Alisal, one at Everett Alvarez, finish Mind Matters curriculum, continue to hold lunch meetings, collect contact logs, follow up on referrals.

April 2022. Hold lunch meetings, collect contact logs, follow up on referrals.

May 2022. Hold lunch meetings, collect contact logs, follow up on referrals, school year ends.

June 2022. Presentations for summer school students, collect any remaining contact logs, follow up on referrals, prepare end of year report.

Total Budget Request 50000

Labor Costs 27183

<u>Please explain/describe your Labor Costs</u>
One student intern to work part time .5 FTE (approximately 48 weeks).

$18.39 x 20 hours x 48 weeks=$17,654
8% Benefit rate=$1,412
Total Benefits and Salary for Student intern=$19,066
Effort will be made to hire Postpone alumna.

Health Program Coordinator to oversee program and supervise staff .05% FTE, $5787
40.26% Benefit rate= $2,330
Total Benefits and Salary for HPC = $8,117

Chronic Disease Prevention Coordinator = in kind

Material Costs 7817

Please explain/describe your Material Costs

- Supplies for trainings (Mind Matters trainings for Peer Educators), handouts, office binders, copies, $1,000
- Projector for presentations $500
- T-shirts, $12each x 30 t-shirts=$360
- Breakfast and lunch for youth participating in full day trainings, snacks for youth while at trainings. $300 breakfast x 2 trainings=$600, lunch $450 x2 trainings= $900
- Mind Matters curriculum by Dibble Institute $325 x 2 facilitators=$650
- Workbooks for instructors and peer educators $15 each x 30 workbooks= $450
- Curriculum binders for training $6 x 30 binders =$180
- mileage to schools for program delivery $1677
- Incentives for training participants such as stickers, pens, pencils, reusable water bottles, and referral cards $1,500

Other Costs 15000

Please explain/describe your Other Costs
$8,000 in gift cards for peer educators. Logs are kept to record all gift cards.
30 Peer Educators, 1 gift card each for 12 months, $20 each gift card = $7200
30 Peer Educators, 1 gift card each, $20 gift card= $600,
Contest 1 $20 gift card for 10 months=$200

•We expect 30 Peer Educators, and each will complete a monthly contact sheet and social media post. They will turn in their log monthly and receive a $20 gift card once a month for 12 months. We will also incentivize them with a $20.00 gift card once they complete at least 75% of the Mind Matters curriculum. We will hold a contest for the best social media post related to mental health; the post with the most likes will be the winner. We will select one winner a month for ten months; winner will get a $20.00 Target Gift Card.

$2,000 - Stipend for two teachers at each site. $1,000 x 2= $2,000

A stipend will be issued to help with cost associated with meetings, teacher support for program activities and scheduling at schools.

$5,000 - Training

• Mind Matters training for staff on curriculum from Dibble Institute and/or other relevant mental health training, conferences = CDPC, Student Intern ($2,500 each)

Community Human Services

Population of Focus

Community Human Services will work with the Monterey County Office of Education's Migrant Education Program to reach over 11,000 Latino migrant children and their families throughout Monterey County, including the Salinas Valley and hard to reach areas of South County. Districts include:

- King City Union School District
- Chualar Union School District
- Gonzales Unified School District
- Alisal Union School District
- Greenfield Union School District
- North Monterey County Unified School District
- Salinas City Elementary School District
- Salinas Union High School District
- San Ardo Union School District
- San Lucas Union School District
- Santa Rita Union School District
- South Monterey Co. Joint Union High School District
- Soledad Unified School District

*30% of MEP students are part of indigenous groups including Mixtec, Zapotec, Triqui and Puretecha of Michoacan.

Problem to be addressed

Latino and migrant farmworkers are a vulnerable population that face multiple threats to their mental well-being. Stress, anxiety and depression are some of the many behavioral health issues migrant farmworkers face. One of the greatest barriers for migrant families in taking advantage of the mental health programs and services available to them, is access. These challenges can be transportation, lack of understanding and knowledge of services offered and a lack of culturally relevant materials. In a report released by the Monterey County Behavior Health Department, Migrant Families were identified as needing assistance in finding and accessing available resources, addressing language barriers, support navigating healthcare enrollment process and accessing referrals to services for basic needs including mental health treatment.

Funds from this grant will go towards creating culturally relevant and linguistically accurate mental health materials curated especially for underserved Latino families in the migrant community of Monterey County. The goal is to leverage the existing relationship between the Migrant Education Program and Community Human Services to engage Latino families by disseminating materials via the MEP.

Proposed Micro-Innovation Activity

Since 2016, Community Human Services has partnered with the Monterey County Office of Education Migrant Education Program (MEP) by providing mental health workshops, parent education classes and co-hosting the annual Migrant Families Resource Fair. It was through this existing relationship that the need for materials to address the mental health needs of Migrant Families was brought to CHS. The MEP fully supports CHS and is eager to connect Migrant Families with the materials to communicate strategies and information to help support them as they work through mental health issues. If funded, our Mental Health experts will work with the 13 Migrant District Leaders to co-create materials that are relevant to their needs.

CHS will use our existing relationship with the MEP to address challenges within the Hispanic/Latinx community and create access to information and materials to this otherwise hard to reach community. CHS will create quarterly (4) culturally relevant and linguistically accurate mental health education materials to engage the Latino Migrant Community and "meet them where they're at."

Communication and Engagement Strategy

CHS will create quarterly information packets addressing mental health issues and disorders migrant families face including but not limited to stress, anxiety and depression. These materials will include contact information for the Monterey County Department of Behavioral Health and Community Human Services to seek treatment if needed. The Migrant Education Program will then disseminate materials to families via direct mail, social media, at school sites and, through Migrant Family Advocates (MFA's), and during regional district meetings.

Evaluation Plan

The desired impact of this program is to provide targeted information and referrals to Monterey County Latino/migrant students and their families that lead to increased enrollment of Latinos/migrant individuals in mental health services. We will track the number of information packets distributed through the Migrant Education program. Demographic data in Avatar will show any increase in engagement of the target population.

Also, each of the thirteen migrant districts have MFA's assigned to students and families. MFA's provide recruitment, record keeping, and supplemental instructional services to students. MFA's will gather interested individual's contact information to relay to behavioral health to seek treatment. We are not sure how many referrals we will receive but our thinking is that the MFA's are trusted resources for many families and that they will be more willing to share contact information with MFA's than with other outreach specialists.

Success in this project will be measured in two ways. The first is simply providing information about mental health and mental health services to a population that traditionally has a low level of access to that information. We will know we are successful by providing information to 11,000 children and their families through a trusted source. The second measure of success will be signing individuals up to receive follow up contact from MCBH, ultimately resulting in enrollment in services. We will know we are successful by the number of referrals MFA's are able to collect.

How many individuals to you plan to serve or reach with your micro-innovation activity? 11000

How many individuals do you plan to refer to mental health services? 200

Timeline

The grant period will be October 1, 2021 – September 30, 2022. We will develop quarterly information packets on the following schedule. Supporting advertising will be scheduled these months, as well.

October 2021 – Suicide Awareness and Resources (October is the highest month for suicides.)

February 2022 – Relationship Building and Healthy Family Dynamics

May 2022 – Topic TBD between CHS and Migrant Education Leaders

September 2022 – Topic TBD between CHS and Migrant Education Leaders

Total Budget Request 24060.5

Labor Costs 4650

Please explain/describe your Labor Costs
Bilingual Communications Coordinator Salary: Hourly rate of $31.00 x 150 hours = $4,650. This will include time to create all materials and to distribute to the Migrant Education Program.

Material Costs 11000

Please explain/describe your Material Costs
Includes copier/paper expenses for material creation. 44,000 pages will be printed (4 printings x 5 pages each = 20 pages per student x 11,000 students = 220,000 printed pages. Cost of .05 cents per page.

Other Costs 8410.5

Please explain/describe your Other Costs
Mileage: $0.545 per mile x 50 miles x 10 trips to distribute materials and attend meetings with Migrant Education leaders (Average of 75 miles per trip/event) = $272.50.

Advertising: $5,000 for supporting advertising on El Tricolor Spanish radio and MST bus billboards. Advertising is optional but recommended.

Admin/indirect: $3,138 for administration (15%). Admin will be reduced if advertising option is not funded.

Awarded Project Descriptions Not Yet Started (Unedited)

Round 6

Door to Hope

Door to Hope (DTH) will collaborate with the Greenfield Union School District (GUSD) to conduct mental health, child development and behavior screenings to better serve an underserved community. The Micro-Innovations grant will allow DTH to connect services to underserved and unserved migrant farmworkers and the Indigenous population within GUSD. Over 2,000 vulnerable families have an established and trusted relationship with GUSD and DTH would like to utilize this connection by increasing the number of families connected to services available in Monterey County.

As of 2019, 40.7% of Greenfield residents were born outside of the country. Trauma endured before, during, and after migration, the struggles with behavioral and mental health concerns including post-traumatic stress disorder (PTSD), anxiety, stress, depression, substance abuse, and/or suicidal ideations pose an immediate threat to their mental health. It is important to consider the unique challenges and lifestyles of this population when it comes to their care, including how we address their mental health needs.

Population of Focus

91.1% of the residents in Greenfield are Hispanic/Latino, Spanish is the most common language spoken at home (47% of the households in Monterey County). However, many from indigenous communities speak neither English nor Spanish. GUSD estimates that 30% of their families speak a native language other than English or Spanish, Triqui is believed to be the language primarily spoken. At the Mary Chapa Academy in Greenfield it is estimated up to 60% of their families speak an indigenous language.

DTH has worked tirelessly to establish trusting relationships with the Indigenous communities within Monterey County. We have adapted to their needs by offering support in completing documents, providing parenting classes, child development education and mental health information and services in Spanish, Triqui, and English. DTH employs staff that speak the language, share in the same culture and live in the communities we serve. DTH staff understands the complex barriers preventing unserved and underserved communities from accessing metal health services. DTH can assist in meeting their needs in culturally sensitive and appropriate ways. The Micro-Innovations grant will allow DTH to assist in breaking the barriers and challenges non- English-speaking families in GUSD face accessing mental health services.

Problem to be Addressed

The Greenfield Union School District has approximately 3,500 students spread throughout 4 elementary schools and 1 middle school. Across the entire district there are only 2 mental health social workers assigned to provide mental health services for students and families. Each social worker carries a maximum caseload of 10 students at any given time. Currently only 20 GUSD students out of 3,500 are provided mental health services by GUSD. Limited access to developmental screenings, assessments, support, and case management is preventing students from accessing mental health services in Monterey County. Student access to comprehensive mental health services is essential to creating and sustaining safe schools.

Collaborative partnerships are crucial for an integrated system of care that includes education, mental, and physical health well-being. Mental illness or mental health awareness within the community is highly stigmatized and keeps families and individuals silent. Men, women and children are reluctant to speak about mental health issues they may be experiencing and often lack the education to even identity a mental health issue. The fear of emotional concerns being dismissed, the stigma around mental health, and the fears of mental health issues being discussed outside the home are a burden on families and individuals. The reluctance to reach out for mental health services is often out of fear of the unknown around what mental health is and what services could be like for a person.

Providing access to intervention services such as mental health screenings, education, case management, and referrals to services will build awareness, trust and confidence within the GUSD community. Creating culturally sensitive spaces will allow students and parents to begin exploring what mental health means to them. Mental health screenings and assessments will lead to referrals

in mental health services for more specialized support and care coordination. A tri-lingual Behavioral Health Specialist will reduce the disparities in order to build the relationships within the GUSD and will result in increased identification and mental health service delivery.

In collaboration with the Greenfield Union School District and the Salinas Valley Memorial Mobile Health Clinic, DTH will provide mental health screenings and referrals to mental health services for the students and families of GUSD. A Behavioral Health Specialist (BHS) native to the community's cultural practices and language, will provide screenings, mental health education, and case management for children 0 to 18 years of age and their parents. Culturally congruent and tri-lingual staff will collaborate with the district's community liaisons and school counselors to identify families with mental health concerns. GUSD will provide Door to Hope's Behavioral Health Specialists with an office to conduct the onsite screenings and education. In addition, once a week our Behavioral Health Specialist will have the opportunity to work side by side with the Mobile Health Clinic providing support for both the health and well-being of the community.

Screenings DTH will provide include:

- Ages and Stages Questionnaire (ASQ): A flexible, culturally sensitive system for screening infants and young children for developmental delays or concerns in the crucial first 5 years of life.

- Ages and Stages Questionnaire - Social Emotional (ASQ: SE-2): A parent-completed, highly reliable system focused solely on social-emotional development in young children. Accurately identifying behavior through ASQ:SE-2 paves the way for next steps—further assessment, specialized intervention or ongoing monitoring.

- Child Behavior Checklist (CBCL): The Child Behavior Checklist is a widely used caregiver report form identifying problem behavior in children and adolescents. The CBCL is a form administered by screeners with answers from parents or caregivers.

- Patient Health Questionnaire-9 (PHQ-9): The 9-question Patient Health Questionnaire is a diagnostic tool to screen adult patients in a variety of primary care settings for the presence and severity of depression. The PHQ-9 is a multipurpose instrument for screening, diagnosing, monitoring and measuring the severity of depression in adults and is administered by a screener.

The Behavioral Health Specialist will use mental health screenings as a tool to provide education around mental health for students and their families in their native language. The BHS will provide case management to students and families and will be available during open office hours to answer any questions or concerns families may have. If the need for specialized mental services and support is identified, students and families will be connected to services. DTH has the capacity to provide access to interpretation and transportation to mental health services in Monterey County assuring all barriers to accessing services are addressed.

Proposed Micro-Innovation Activity

Through our continued work within Monterey County, DTH has witnessed an increase in the success rate in specialized services accessed by underserved and unserved communities that is highly dependent on the support the family receives before and after the referral process. It is imperative that families referred to services understand why and how services will benefit their family. It is also crucial for the referring provider/case manager to remain connected to the family until the family

has established a strong connection to the new service as we know there are countless barriers that can come in the way of a successful connection.

Adapting mental health screenings and expanding access to Non-English-speaking individuals within the migrant farmworkers and Indigenous communities of the Greenfield Union School District helps students and families understand the importance of advocating for their own mental health and to trust in the delivery of health, behavioral health and social services that Monterey County has to offer. Building trust and confidence through mental health education and screenings improves student and parent outcomes creating a sustainable and safe space.

Students and parents that have experienced complex trauma and live with mental health issues may struggle with attachment and emotional regulation along with day to day functioning. DTH Behavioral Health Specialists will work diligently to build and gain the trust through meaningful conversations introducing Monterey County's mental health services to the migrant farmworkers and indigenous populations of GUSD. DTH Behavioral Health Specialists will be culturally responsive in their screenings and help educate this population on the importance of mental health services so there is an increased overall awareness to access services.

In order to succeed in connecting the migrant farmworkers and Indigenous communities with mental health services Comprehensive Case Management (CCM) must be provided. Case management is "a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive needs." DTH's case management is a coordinated approach to the delivery of health, behavioral health, and social services, linking clients and families with appropriate services to address specific discerned needs and to guide families in meeting identified goals and outcomes. By supporting these families in a way that helps them understand the importance of advocating for their mental health and not being deterred from seeking support we can significantly build trust and confidence to this population to improve student and parent outcomes.

A collaboration between the Greenfield Union School District and Door to Hope is unique, innovative and will promote fundamental improvements in seeking mental health services by students and families of the GUSD. Current mental health needs are not being sufficiently addressed or met by GUSD. Due to lack of resources and staff, mental health screenings, education, and case management services have not been developed between GUSD and other agencies. DTH would build on an existing relationship between GUSD and their families to provide the needed mental health education, screening and support. The integration of these practices delivers mental health information in a cultural and linguistically appropriate manner to a group with many language and cultural barriers.

The Greenfield Union School Districts Family Resource Center is a community hub that will provide an office for Door to Hope's Behavioral Health Specialist allowing for one on one interaction with families seeking resources and support. The Family Resource Center is a "One Stop Shop for Resources" with over 20 years of experience. The Family Resource Center is connected to all GUSD counselors, teachers, students and their families providing resources to Monterey County Services. Door to Hope will expand the Family Resource Centers capacity to families with children 0 to 18 years of age who are at risk for mental health problems.

Door to Hope currently provides:

- Parent education services

- Circle of Security
- 15 playgroups each week in South County
- Serve over 100 families in target population
- Tri-lingual English, Spanish, and Triqui capacity.

Communication and Engagement Strategy
Our staff is already known and trusted in this underserved community. We provide parent education and play groups through contracts with First 5 Monterey County for families with young children ages 0 to 5 years old. We have excellent outreach and engagement strategies with the targeted population and community.

DTH is continuously monitoring and responding to the evolving situation around COVID-19, including taking special precautions to ensure the safety of clients and staff. Door to Hope has completed a detailed risk assessment, modified its facilities, and changed its practices to meet CDC guidelines and the current California Shelter-in-Place requirements for Monterey County. We have and will remain operational during this time with some modifications to the services we provide. Our staff has worked tirelessly connecting families to current virtual platforms and has had proven success. We are currently providing services to families virtually and in-person individual home sessions and playgroups. We have great attendance in all that we offer. We can offer in-person sessions and virtual.

Evaluation Plan

DTH's Behavioral Health Specialist will provide students and families in the GUSD with mental health screenings, education and case management services using the industry-leading case management platform Apricot 360.

Apricot 360 combines case management with advanced data reports and analytics while connecting clients to services and providing comprehensive care. When needs for further mental health support are identified, our BHS will assure families are connected and receive services. Each BHS will be responsible for monitoring the number of families served and the number of referrals provided.

Greenfield Union School District Counselors and the Family Resource Center Community Liaisons will have the capability to refer appropriate cases to this Micro- Innovations grant program. Our Behavioral Health Specialists will review referrals and ensure both the student and family needs are met. Referrals will be tracked through our Apricot 360 database until the outcome is reached. The DTH Behavioral Health Specialist will reach out to families routinely to gather information and provide support. All services provided and outcomes will be documented in Apricot 360.

Door to Hope has extensive experience and relationships with many of our county's mental health services. In addition to MCBH we can also refer families to our own ICT and MCSTART programs as well as Harmony at Home, Community Human Services, PVPSA, Seneca Family of Agencies, Interim Inc., Sun Street Centers, Monterey County Probation Child Advocacy Program, Bienstar, and Centro Binational para el Desarrola Indigena.

How many individuals do you plan to serve or reach with your micro- innovation activity? 150

How many individuals do you plan to refer to mental health services? 50

United Way Monterey County

Population of Focus

The population focus for this work will be distressed Latinx youth in Salinas zip codes: 93905, 93912, 93915. Our intervention will target at risk youth who are experiencing mild to moderate mental health issues related to stress, anxiety, and depression.

The United Way Monterey County led a Countywide aspirations assessment in the summer of 2019. When we asked adult survey respondents to weigh in on their biggest health concerns, 57% told us that unmet mental health needs were a significant problem in their communities.

Among youth participants in 2019, top concerns consisted of diet, obesity and diabetes, unmet mental health needs, and drugs, smoking and alcohol abuse.

The 2020-2021 Monterey County Children's Council report documented that 19% of suicides were committed by children under 17, and 57% of attempted suicides were by children. The report also shows a significant increase in drug abuse and fatal overdoses for youth 15-24 during this time period. From March 2021 to March 2022, there were 1,764 calls for mental health supports to 211 in Monterey County. 55% of those calls came from Salinas.

The 2020-2021 Monterey County Children's Council report cites that the COVID-19 pandemic disrupted the lives of children and adolescents. Disruptions included in-person schooling, in-person social opportunities with peers and mentors, access to health care and social services, food, housing, and the health of their caregivers. The pandemic has exacerbated the overall mental health

challenges for children and youth as a result of isolation, fear, stress, and uncertainty. Their families also experience stress related to employment, wellness, and insecurity. Post pandemic, children in our community are facing trauma because of: child abuse; loss of a family member; decreased academic engagement/performance; extended period of social isolation; as well as everyday anxiety about the virus and unpredictable routines.

A report issued by the UC Davis Center for Reducing Latino Mental Health Disparities, cited, “five major themes related to individual-level barriers: (1) stigma associated with mental health problems, (2) cultural barriers, (3) masculinity, (4) violence and trauma, and (5) lack of knowledge and awareness about the mental health system.”

Problem to be Addressed

The 2012 report issued by the UC Davis Center for Reducing Latino Mental Health Disparities, cited several themes related to individual-level barriers preventing access to mental health services. Negative perceptions about mental health care are perceived as a significant factor contributing to limited or no access to care. Among the many concerns, stigma, culture, masculinity, exposure to violence, and lack of information and awareness were the most common. These barriers persist today in Monterey County.

Latinos with limited English proficiency frequently do not have critically important information, such as how and where to seek mental health services. Moreover, language barriers contribute to the problems Latinos face when accessing public transportation to visit mental health clinics. Additionally, many Latinx residents are reluctant to provide required social security numbers and other personally identifiable information when completing mandatory paperwork at clinics.

A lack of sufficient bilingual and bicultural mental health professionals is another barrier. This usually translates into language barriers and often results in miscommunication and misinterpretations.

Focus group interview participants reported that limited or no access to mental health services was a significant factor affecting the mental health of the Latino community. There are limited social emotional and mental health programs and supports targeting Latinx youth. Those that exists are difficult to access.

In addition, the social determinants of mental health are barriers. These refer to the social conditions in which people grow, live, work, and age, and which have a powerful influence on people’s health. In particular, social and economic resources and living conditions; inadequate transportation; and social exclusion can be factors restricting access to mental health services.

What product/service is your micro-innovation providing to this population of focus to address the barrier(s) described above?

The report issued by the UC Davis Center for Reducing Latino Mental Health Disparities indicated several core strategies to increase mental health supports to vulnerable Latinx residents:

Implement peer-to-peer strategies, such as peer support and mentoring programs, that focus on education and support services.

Create a meaningful educational campaign that is designed to reduce stigma and exclusion and

that targets individuals, families, schools, communities, and organizations and agencies at the local, regional, and statewide level

Building individual and family resilience (promoting connectedness, develop support networks, increased coping skills and parenting skills), building protective environments, strengthening economic supports for families, increasing awareness of mental health and suicide risk factors, and increasing access and delivery of mental health care

To address the barriers, youth experience in accessing mental health supports and implement recommended solutions, United Way Monterey County (UWMC) and its partners: The Boys and Girls Club on Monterey County; the Center for Community Advocacy (CCA), & Mujeres en Accion (MEA) will engage in the following activities in Salinas:

CCA & MEA Promotores de Salud serve as liaisons between mental health services and vulnerable Latinx youth and their families. Promotores will perform outreach activities, including sharing information on mental health issues and sending closed loop Smart Referrals to CCA and Boys and Girls Club youth programs that support: youth resilience, healthy lifestyles, compassion, self-efficacy, agency and leadership. In addition, BGC programs provide the following trauma-informed practices supporting emotional wellness:

- Provide opportunities to develop positive peer and staff relationships.
- Integrate opportunities for youth voice in activities, programs, and spaces.
- Create a safe and comforting physical environment.
- Adapt activities when needed to better support youth needs.
- Identify and refer youth to more specialized services when needed, ex: behavioral health agencies.

To build capacity, the Promotoes de Salud will receive training on common mental health issues Latinx children are experiencing as a result of the pandemic and adolescence. They will learn how to identify symptoms and provide psychological First Aid, tips, guidance, and community conversations (Platicas).

Promotores, youth, and families will also use the Smart Referral Network (SRN) bidirectional referral tool to make “closed loop” referrals to mental health support services. Service providers will monitor their SRN inboxes and document when referrals result in services.

Proposed Micro-Innovation Activity

The SRN is “smart” in that it compares client demographics with eligibility of services in the Monterey County 211 database to prioritize search results. Promotores will use the SRN to refer to additional Monterey County health and human services families may need.

To increase access and build capacity, UWMC will develop software on top of the SRN to allow families to “Smart Refer” themselves to the Boys and Girls Club program and other Monterey County health and human service programs. Prior to developing the software, we will conduct focus groups with youth and their families about how best to design and implement the software in a way that is effective and culturally appropriate.

How will your product/service promote this population offocus to seek mental health services when the need formental health services has been identified?

Trained Promotores de Salud will perform culturally competent outreach activities, including sharing informationon mental health issues and available services to vulnerable Latinx youth and their families in areas with historic lack of access to mental health services. Their interventions will target schools and housing developments that feed into Boys and Girls Clubs centers and programs. Promotores would provide mental health tips and guidance to those they identify as needing support. They will hold community conversations (Platicas) about common issues vulnerable Latinx youth are experiencing and attempt to reduce stigma and mental models related to negative perceptions of using mental health services. When they identify needed support, they would use the United Way Smart Referral Network (SRN) platform to do an intake, release of information, eligibility screening and electronic referral on behalf of a community member to a Boys and Girls Club program in Salinas. The parent or guardian would be referred as a proxy for their child. Additionally, UWMC will develop "chat bot" software to allow families to "smart refer" themselves to the Boys and Girls Club program and other Monterey County health and human service programs. The "Chat Bot" would live on public library and other community computers to allow parents to self-refer their children to the Boys and Girls Club program. Prior to developing the software, we will conduct focus groups with youth and their families about how best to design and implement the software.

The SRN is a HIPAA compliant program that protects client Protected Health Information and Personally Identifiable information. All Referrals and social determinants of health (SDOH) Reports made for clients with referrals to mental health programs are protected. Only users with granted access will be able to see protected information: Any information regarding the source of the referral. This includes:

- Program Name
- Agency From
- Referring User Contact Info

Any information regarding the outcome of the referral. This includes:

- Enrolled / Accepted / Declined

How is this innovative?
This approach is innovative for the following reasons: The Smart Referral Network (SRN) has not been used to facilitate access to mental health services. While many referral processes exist, none exist that allow for electronic sending of referrals and documenting when referrals result inservices. We will also develop a new feature that will allow parents themselves to send Smart Referrals for their children to participate in the Boys and Girls Club program. Our program approach will address the emotional and psychological stress parents and youth are experiencing by accessing youth to structured activities, mentoring programs, and youth leadership programs that:

- Match youth experiencing individual or environmental risk factors i.e. struggles with peer relationships and/or have been bullied, housing instability, or incarcerated parent to role models
- Provide robust learning, hands-on projects, guest speakers and field trips
- Provide a health, fitness, prevention/education, and self-esteem enhancement
- Addresses critical issues adolescents face including parenthood, decision-making and employment
- Where applicable work with an assigned mentor one-on-one for a minimum of one hour a week.

While program practitioners are not licensed clinicians, there is evidence that when youth are engaged in safe, predictable, structured activities with caring adults, they can reduce anxiety, depression, and mitigate post traumatic stress disorder. Parents' anxiety and stress are lessened by knowing their children are in developmentally appropriate and safe programs and have the ability to work and provide for their families.

Communication and Engagement Strategy

How will you reach and interact with your identified population of focus to deliver the product/service(s) of your micro-innovation activity? Center for Community Advocacy and Mujeres en Accion Promotores de Salud are integrated in our targeted communities. They are respected leaders and have existing relationships with parents and youth. After receiving training, they will offer mental health tips and guidance to those they identify as needing support. They will hold community conversations (Platicas) about common issues vulnerable Latinx youth are experiencing and attempt to reduce stigma and mental models related to negative perceptions of using mental health services. They will make Smart Referrals to Boys and Girls Clubs programs and monitor referrals to ensure families receive services. These health care workers are essential to this intervention in that they live in the targeted communities. They are trusted voices that will communicate and engage about mental health in culturally competent ways. Boys and Girls Club will hold centralized orientation and registration events in a safe venue close to families. They will provide program information and answer parents questions. Where possible, Boys and Girls Club will offer transportation to programs for children that register for programs.

If your activity involves in-person contact, please describe how you will take precautions against the spread of COVID-19 and observe current Shelter-in-Place restrictions. Any program contact that involves in person contact will follow Monterey County and State of California public health guidelines for school, child care programs and community meetings. For example we would follow social distancing and face covering requirements when guided to do so by the Monterey County Health Department.

Evaluation Plan

How will your micro-innovation activity provide individuals with information and referrals to obtain a clinical appointment? Who, as part of your project, will be responsible monitoring the number of referrals that are provided? Promotores de Salud will serve as liaisons between mental health services and vulnerable Latinx youth and their families. Promotores will perform outreach activities, including sharing information on mental health issues and sending closed loop Smart Referrals to Boys and Girls Club social emotional support programs for youth. The Smart Referral Network (SRN) bidirectional referral tool allows users to make “closed loop” referrals to mental health support services. Service providers will monitor their SRN in boxes and document within the platform when referrals result in services. To increase access and build capacity, UWMC will develop software to allow families to Smart Refer their children to the Boys and Girls Club program and other Monterey County health and human service programs. Prior to developing the software, we will conduct focus groups with youth and their families about how best to design and implement the software. The United Way will monitor and report on referrals made in the SRN and that result in social emotional services in order to understand the effectiveness of the intervention. In addition, the Boys and Girls Club completes a weekly tracking sheet for children experiencing more moderate mental health issues. The tracking tool will document changes in targeted behaviors, program participation, other supportive activities or events, challenges, issues and concerns. Aggregated results data can be compiled to demonstrate overall improvements from children who participate in the program. Program challenges and lessons learned can be documented and reported. The Boys and Girls club will also provide aggregated data on those referred from the SRN. They will report on how many accessed services and how many continued to receive services.

Another component to this intervention will be pre and posttests administered during the community conversations.

These will be helpful in developing a baseline understanding of mental health mental models, knowledge, and barriers. This will be critical to tailoring future conversations andinterventions.2. How will you gather information from referred individuals to know if they were able to access/attend at least one appointment?

The Boys and Girls Club will receive an email notification when they receive a Smart Referral from a Promotores de Salud or parent. The email will inform them that a client has been referred and they should log in to the Smart Referral Network to access the parent's contact information. To ensure confidentiality, no information about the parent will be shared in the email. They will then reach out to the parent and attempt to enroll their child/children in their programs. When the child has attended at least one appointment, they will click "Enroll" in the SRN. This will indicate to UWMC staff with access credentials that the referred individuals benefited from services.3. In addition to MCBH, will your micro-innovation provide referrals to other agencies for mental health services? If so, please specify.

The Smart Referral Network (SRN) compares client demographics with eligibility of services in the Monterey County 211 health and human service database to prioritize search results. Over 40 community benefit organizations have signed an agreement with the United Way to respond to Smart Referrals and keep service information up to date. Available services include emergency food and shelter, childcare, support for individuals with disabilities, housing resources, financial literacy education and coaching, substance use disorders, domestic violence, and adult education. Many of these services provide mental health supports. Promotores will use the SRN to smart refer to additional Monterey County health and human services families may need.

How many individuals do you plan to serve or reach with your micro- innovation activity? 50
How many individuals do you plan to refer to mental health services? 75

Precious Stone PR Inc.

Thank you for the opportunity to submit this proposal to assist in disseminating important information about Mental Health to the Latino Community via a PSA Marketing Strategy. Public Information Announcements work well in our area because the media have to allot certain time to public services.

I am counting on my media partners to continue to support these efforts especially when these benefit Latinos and the LatinX community in a big way.

Population of Focus
In Monterey County, most of the first and second generation Latinos are of Mexican descent and speak Spanish. Some come from regions in Mexico that speak in dialects (Mixteco, Zapoteco, Triqui). This plan will cross over County lines into San Benito, Santa Cruz, and a bit of South Santa Clara Counties because of the nature in tools to be used to spread the information (TV/Radio). For Monterey County, the focus will be the 101 HWY corridor which expands over 100 miles from Prunedale, Salinas, to South of King City. Other cities that will benefit are Seaside, Marina, Castroville, which house a great number of Latino families.

In the last year, MCBH and its investment in PSAs in Spanish via an Innovation Grant, went a long way. The Spanish speaking population was actually calling the numbers seeking help! This is what we want them to continue doing.

With nicely edited storyboards on TV and Radio, and in their language, mental health is not as much a taboo as it used to be. With a new series of PSAs, I expect for that cultural avoidance of mental health services to lower. We need to let the Latinos that is okay to seek help. The PSAs help in putting families more at ease and willing to make that call for themselves of for their family.

Problem to be Addressed

In the Latin American culture, in general, mental health services are avoided at the fear of being labeled as insane, retarded or weak-minded. The reason Latinos don't seek mental health services is mostly cultural, but these can be molded or adjusted with good information from trusted sources. Nowadays, more layers of trauma have been added to the already vulnerable communities. The Coronavirus, social and political unrest, etc. have created even more anxiety in Latino youth and adults. A lot of Latinos in our communities face a lot of challenges each day, especially if they are undocumented or live in poverty or both. Gangs and drugs are infiltrating themselves into families creating destruction that cannot be repaired because help is avoided. Monterey County faces a lot of uncertainties for Latinos who deep inside, wish to do their best but are labeled even before they speak or do anything. This is not a good way to live. But even though Latinos are facing all these challenges, day in and day out, they are too proud to seek help.

There is no better way to target thousands at a time than by using television, radio, and social media all together in an intentional and bold way.

Proposed Micro-Innovation Activity

I am excited to propose a 'Telenovela' style PSA project for this next round of Micro-Innovation grants. I will have one of these PSAs be in Triqui and one in Mixteco.

I have worked in Monterey County and in the Central Coast since 2005, first as a journalist and later as an expert in Marketing and Public Relations. I have also volunteered for non-profits, mentored youth and continue to do so, plus being key note speaker at various graduations and special events. What I have learned is that the need for Latinos to get help in mental health is huge. My friends from Partners from Peace (Vicki Law), Harmony At Home (Julianne Leavy), Girls Inc. (Patty Fernandez), Hartnell College (Jackie Cruz), plus others in the media and other organizations agree that services are underused and something needs to be done about it. These organizations know how much their clients need mental health services. They all love the idea of creating a marketing plan designed to cater to this population in particular.

Communication and Engagement Strategy
Being a journalist and an expert in marketing places me in a position of creativity and accessibility. I have contacts in the region that will continue to provide me with air time to get the information broadly shared.

I plan to ask local Latino leaders in the community to be the face in some of the commercials to create relevance and familiarity. I will use my media expertise to place the PSAs in all Spanish speaking media in the Central Coast and seek opportunities with organizations that want to feature the PSAs on their websites or social media (like Partners For Peace). If this proposal is accepted, the first month would be about the production of the 12-month plan, which would include the production of the first PSA. I will call in key individuals in the community and experts in mental health services to be a part of an advisory committee that will help me stay on track and to monitor, evaluate, and adjust the plan.

I will make myself available and when possible have an expert with me for media interviews, shows, radio interviews, etc. In addition, I have found my press releases to be effective. The media loves information that is already written and I know exactly what they want and how they want it in order to be assured that the story or information will appear in the evening news that day.

Evaluation Plan

The evaluation has come easy. More people calling the help lines, more clicks on the website, more

people healing.

When you deal with Television and Radio, it is very difficult to tell how effective something you promote is.

But, the rule of these two is that if one person says that they heard or watched it on TV/Radio it counts for 1,000 people. I can evaluate this project by creating a simple survey to use right at the start of the project and then again at the end, BUT I believe that hearing from MCBH staff who respond to the help lines is a better testimonial of how much the calls have increased.

How many individuals to you plan to serve or reach with your micro- innovation activity? 60000
How many individuals do you plan to refer to mental health services? 10000

Denied Project Descriptions (Unedited)

Round 4

Jorge Rojas/ Monterey County Soccer Club

Population of Focus
Our population of focus will be individuals from Central America and Mexico, some with dialects from their region in which they came from. Our region will cover Monterey Peninsula, North County, Salinas and South County.

Problem to be addressed
The challenges facing this diverse population is that there are cultural barriers that we will be addressing to make the connection. For example, in South County the indigenous families from Oaxaca, one is to approach the male in the household before approaching the female which is a norm in that community. There are rules of engagement that we will be following to make sure we exercise cultural sensitivity. Having had multiple trainings in cultural sensitivity and other pertinent trainings, I feel that I can use that skill to train our team in being successful in making the correct connection with the families we intend to serve.

Proposed Micro-Innovation Activity
1) While many modern lists emphasize the minimum level of consumption of 'basic needs' such as food, water, clothing and shelter, our organization will also focus on sanitation, education, and healthcare. Once the basic needs are met, then seeking mental health services would be the next step in making sure the identified population gets the needing services. We would have a person on our team with training in mental health services and identification to help our team be better prepared. This person would also serve as the Facilitator once we start meeting with the families. We would provide wrap around services for the entire family.

2) Once the foundation is set in terms of the population to be served has the basic necessities, then "trust" would allow us the opportunity to refer our targeted population to seek mental health services. Having done work throughout the county, I have been able to make contact with all the diverse indigenous groups and have earned their trust.

3) This project is innovative as it would be the first time reaching this diverse population. Through our organization, Monterey County Soccer Club, which is the largest soccer organization in the tri-county and perhaps Northern California, we are able to connect with lots of members through the sport of soccer as most are current members in our organization and live throughout the county. Having over

6,000 members, and still growing, provides us the opportunity to reach out to the population we intend to serve.

Communication and Engagement Strategy
1) We will be reaching our identified population via soccer tournaments, sporting events and Soccer Finals to deliver our services. We will also announce scheduled events within different areas of the county to invite the community to attend and offer raffle prizes.

2) Our members of our organization will practice social distancing protocol. Our involved members will attend an orientation that will address the steps that we will be covering and breaking up the county into segments and make sure that we cover the identified population. Having participate in census counts, Housing Inventory Counts, Point in Time Counts throughout the county has allowed me to learn the skills to make sure that we cover all segments within our County.

Evaluation Plan
1) Our organization will establish and identify a Point of Contact within the Health Department to make the referrals and do a warm handoff once we start processing the referrals. Every team member in our organization will be responsible for tracking data and referrals provided. We will also do follow ups to make sure that the person who was referred, attended their session and received the necessary care that was needed.

2) We will create in intake system where we will be tracking our clients via excel to make sure no appointments were missed. If transportation is an issue, we will make sure to provide transportation to and from the site to make sure that no appointments are cancelled or missed.

3) Our organization will only provide referrals to MCBH and if the services are not adequate for the referred individual, then MCBH can make the decision to refer to another organization. We will make referrals to other non profit agencies in regards to other needs such as employment, housing, food, etc. Having worked with all non profit organizations in Monterey County, I have developed a good working relationship and have inside person from the organization based on the needs of the referred person.

How many individuals to you plan to serve or reach with your micro-innovation activity? 100
How many individuals do you plan to refer to mental health services? 40

Rocio Quintero/Gonzales Citywide Outreach
Population of Focus
Population of focus will be the Latino/a community of Gonzales who are in need of mental health support.

Problem to be addressed
Many within the Latino community go through mental health issues alone, whether that is because of stigma, not understanding that help is out there, or not knowing where to look for resources. Many suffer in silence and their suffering unfortunately contributes to a slew of other issues such as domestic violence, alcoholism, drug addictions, etc. The current COVID-19 pandemic has only exacerbated the issue and now unfortunately we have an alarming number of individuals feeling anxious, distraught and helpless. Entire family units are struggling and individuals of all ages, especially adults, don't know where to turn for help.

Proposed Micro-Innovation Activity

Though the activities proposed we will be providing a multitude of opportunities for community members to engage in mental health services. We know that one solution does not address the different problems that people are facing during this time and there is not a one size fits all way to engage everyone needing support. Therefore, our proposal offers a variety of opportunities by which individuals can first engage in services in a manner that makes them feel comfortable, safe and supported. By being able to provide a safe and encouraging environment for them through opportunities like painting classes, support groups and calming corners we will be able to begin engaging the public in an effort to share mental health resources and be able to connect them with the behavioral health system while assuring them that they are not alone. Additionally, our community health workers are trusted members of the public who are currently working on supporting COVID-19 relief efforts and who are encountering many individuals in need of mental health supports. Through their service they are working to build trust and relationships with the community and with this additional support they can make referrals and encourage the public to seek out much needed mental health services. Working collaboratively on this effort with help to streamline the way individuals from the City of Gonzales and its outskirts get connected to services.

Communication and Engagement Strategy
GUSD staff will utilize creative methods of engagement such as; Phone calls, snail mail, e-mail, flyers, text messages, voicemails, social media and canvassing. Additional engagement strategies include free food for participants, “goodie bag” filled with resources (mental health & covid) and access to mental health specialists. Community Health workers will collaborate with GUSD District Social Workers and will also provide referrals to MCBH upon encountering members of the public needing mental health support.

Evaluation Plan
At the end of every community mental health presentation we will provide the participants with a feedback survey in English/Spanish for presentation feedback and to evaluate the ongoing needs and address them. In addition we will provide a pre and post mental health test to determine if participants learned the skills and tools to address their own and families mental health needs. Data will be continually logged and tracked (demographics, engagement, attendance, referrals, referral outcomes) and all referrals submitted to MCBH will have case management follow up by GUSD staff to ensure linkage to services with MCBH.

How many individuals to you plan to serve or reach with your micro-innovation activity? 1000
How many individuals do you plan to refer to mental health services? 250

Emeralda Owen/Precious Stone PR
Population of Focus
This is a DIGITAL MARKETING idea to help disseminate information about mental health services in Monterey County to the Latino population. I have found this to be the best way to reach those we want to reach in a targeted and intentional way. Most of the first and second generation Latinos who live in the County are of Mexican descent and speak Spanish. Some come from regions in Mexico that speak in dialects (Mixteco, Zapoteco, Triqui). This plan will cross over County lines into San Benito, Santa Cruz, and a bit of South Santa Clara Counties because of the nature in tools to be used to spread the information (TV/Radio/Social Media). For Monterey County, the focus will be the 101 HWY corridor which expands over 100 miles from Prunedale, Salinas, to South of King City. Other cities that will benefit are Seaside, Marina, Castroville, which house a great number of Latino families.

Problem to be addressed

In the Latin American culture, in general, mental health services are avoided at the fear of being labeled as insane, retarded or weak-minded. It is taboo. The reason Latinos don't seek mental health services is mostly cultural, but these can be molded or adjusted with good information from trusted sources. Nowadays, more layers of trauma have been added to the already vulnerable communities. The Coronavirus, social and political unrest, etc. are creating even more anxiety in Latino youth and adults. A lot of Latinos in our communities face a lot of challenges each day, especially if they are undocumented or live in poverty or both. Gangs and drugs are infiltrating themselves into families creating destruction that cannot be repaired because help is avoided. Monterey County faces a lot of uncertainties for Latinos who deep inside, wish to do their best but are labeled even before they speak or do anything. This is not a good way to live. But even though Latinos are facing all these challenges, day in and day out, they are too proud to seek help. But if they hear it from a trusted source or see it in their language, they will more likely seek assistance.

Proposed Micro-Innovation Activity
No matter how rich or poor you are, reality is, you have a cell phone. This is why a Digital Marketing Campaign can be really effective in sending messages to whoever we want and as many times as we tailor it to be delivered. The power of technology allows us to now select regions, areas, people of certain ages, of certain styles, of certain anything to get the message you need delivered. With this campaign, I will create graphic designs to disseminate broadly. I would also utilize already produced PSAs (or produce new ones) to pop up for some of the clients. In addition, graphic designs will also be spread via social media by feeding them to community partners so they can post them on their timeline. For Latinos, sharing stories of other Latinos that are dealing with mental health issues and how they are overcoming them builds trust; for they to know that services are available in their language, free or not, and provided regardless of their legal status is key. In addition, pointing out what mental health issues look like and creating messaging that allows for acceptance. With the Digital Campaign and any campaign, some messages will be tailored as informative, some will be designed to take action. For the latter, I recommend having a phone number or a page on your Website that is designed specifically for this campaign. This will also help to track the progress of the campaign and serve as an easy way to get referrals or get paired up with the right program.

Communication and Engagement Strategy
I will create the timeline for this project and design the digital marketing concept, month to month. I will work with the local digital marketing expert to upload the concept and track how it is doing. With digital marketing, it is easy to get day to day reports on how many people are reached. They have the tools to give us weekly, monthly, and annual data to evaluate. A graphic designer will need to help me create the ads for dissemination. And PSAs that already exist or are being created by another consultant (or me) will be used on a monthly basis. An intern will be hired to help get all messaging on social media platforms with consistency.

Evaluation Plan
The evaluation can take place on a monthly basis. I will use analytics, number of clicks on website, number of calls, number of likes on social media.

How many individuals to you plan to serve or reach with your micro-innovation activity?
25000

How many individuals do you plan to refer to mental health services? 5000

Timeline

This plan is for one year. The information to be disseminated will be designed in a timeline. Each month we will focus on different programs, graphics, themes.

Total Budget Request
50000

Labor Costs
20000

Please explain/describe your Labor Costs
Project manager wages for the year. Intern stipend.

Material Costs
28000

Please explain/describe your Material Costs
Costs of digital marketing services for one year. Graphic designs.

Other Costs
2000

Please explain/describe your Other Costs
There will be costs of mileage, cell usage, meetings (meals), liability insurance for contractors, any other media tool needed, plus any other overages.

Round 5

CSUMB MSPA
Population of Focus
Migrant farmworkers in Monterey County and South County.

Problem to be addressed
Patient are not given tools to address daily stressors of life. There is a time lag to get in to see a mental health provider. We plan to close the gap by offering tools that patients can practice at home to improve their mental health.

Proposed Micro-Innovation Activity
We plan to offer a curriculum of mindfulness, meditation, decentering to these at risks groups by creating focus groups and having our faculty and PA students lead the trainings.
This gives our students exposure to this at risk population utilizing the curriculum they have learned during their tenure at the PA program. All of our students are fluent in Spanish.
This will give our population tools to cope with until they get to see their provider.
The proposed project has not been done in Monterey county.
It is innovative in that we are meeting our program's mission of serving the undeserved and we are able to fill the gap of the lag time from onset of mental health systems to appointment time. While having these tools, the patients will be referred to their providers and be given a strategy to cope at home.

Communication and Engagement Strategy

We plan to advertise at local farmworker health clinics in our area since we have many connections with mental health providers that our student do their internships at. We also have a strong relationship with Monterey County behavioral medicine.
We will create times where we can meet with the groups of patients and offer mindfulness curriculum.
All of our students/faculty/staff are doubly vaccinated against Covid and are required to wear PPE.

Evaluation Plan
We will appoint a lead to monitor the number of referrals provided.
We plan to partner with the local health clinics to get access to their pamphlets for mental health referrals and Monterey County behavioral medicine.
We would work with the clinic they were referred to monitor the number of appointments.

How many individuals to you plan to serve or reach with your micro-innovation activity? 100

How many individuals do you plan to refer to mental health services? 100

Timeline 12 months

Total Budget Request 1000

Labor Costs
100

AIM Youth Mental Health

Population of Focus
The focus population this program will serve is Monterey County teens (ages 14 - 18), their parents, and high school educators and counselors, with an emphasis to serve ESL / Spanish native Hispanic / Latino youth in the Salinas Valley, North county, and South county regions. A large percentage of these students are among a lower socioeconomic status (LSES) who've been most affected in mental and physical distress due to the COVID-19 pandemic; especially those living at or below the poverty level with high density home conditions. In Monterey County, Latinos and Hispanics make up over 60 percent of the population, but over 84 percent of hospitalizations and over 75 percent of COVID-19 deaths. Pre-pandemic, these groups already experienced higher rates of need as mental health and addiction conditions are often activated or exacerbated by social determinants of health such as poverty. In the US, children under 18 years old are disproportionately affected by poverty, making up 33% of all people in poverty. Living in a poor or LSES household has been linked to poor health and increased risk for mental health problems in both children and adults that can persist across the life span.
Despite the mental health needs of Monterey County families living in poverty, few have sought access to participate in mental health services activities. There is a growing urgency and ripe opportunity to develop integrated models of mental health care that are tailored to the needs of these vulnerable children and their families.

Problem to be addressed
Monterey County teens, particularly in Hispanic/ Latino communities living in poverty, face a range of barriers that reduce their interest and/ or ability to access mental health services, maintain compliance with treatment, and achieve favorable treatment outcomes.
Our local teens and their parents experiencing poverty encounter social and psychological barriers:
The stigma of mental health treatment

The stigma of living in poverty may generate self-blame and self-loathing, which may inhibit seeking care.

- Parents raising children in poverty, particularly mothers, may fear being labeled “crazy,” concerned that a diagnosis may cause their children to be removed from their care.
- Mistrust of the mental health care system, perceiving that any disclosure of mental health problems may result in hospitalization, overmedication, or separation from children and family.
- Misaligned messaging and/ or gaps in cultural competency among mental health resources and stakeholders

Instead of seeking treatment, these teens and their families may rely on their own limited coping skills, support from peers, or ignore the mental distress altogether. Even when treatment is being sought, socioeconomically disadvantaged teens and families face greater difficulty with treatment engagement and, even when they complete treatment, may not benefit to the same extent as higher-income families.

Consequently, there is a need for more upstream, innovative, comprehensive approaches to address mental health problems among teens and their families experiencing poverty in Monterey County. Specifically, innovative programs that have families engaged, teens in their natural contexts, incorporate evidence-based interventions (emphasizing research findings), and take a comprehensive culturally-competent approach to treatment that addresses relevant social determinants (eg, housing or food insecurity) may be associated with greater therapeutic assessment, diagnosis, and increased completion of treatment.

Proposed Micro-Innovation Activity
There is a growing consensus among specialists in pediatrics, psychiatry, psychology, and child advocacy that integrating mental health services into existing services settings, including pediatric primary care and educational institutions, is the most promising means of increasing access to mental health care, particularly for children from low-income families.

Simultaneously trending, school districts across the country are developing a new kind of partnership with researchers in long-term collaborations that are organized to investigate problems of practice and generate solutions for improving outcomes. This is particularly useful in schools supporting the roll out of new mental health initiatives. In the context of a mental health prevention, intervention, and education, strategic research-practice partnerships can foster reciprocal learning and develop effective mechanisms for broad communication and co-management of mental health referral needs between providers including clinical researchers, primary care clinicians, mental health professionals, school personnel, and case managers.

Innovative youth mental health approaches must go beyond overcoming stigma campaigns, and commit to initiatives which regeneratively elevate youth voices in mental health research and clinical practice priorities. New and creative ways to engage teens in discussion with peers and mental health experts, while directing insights and assessed needs to clinical research and mental healthcare practice is essential to address youth mental health issues.

In response to both the need and opportunity, AIM Youth Mental Health, a 501c3 nonprofit based in Carmel, will be launching the AIM Ideas Lab, a unique youth participatory action research (YPAR) pilot program to extend mental health education, prevention, and intervention with high school students, educators, youth counselors, parents, and youth serving organizations in Monterey County, CA.

The purpose of the Lab is to:
- Engage youth in the mental health conversation,
- Raise awareness of the need for the science/research to find solutions,
- Build advocacy for mental wellness,
- Include youth with lived experiences in the research strategic decisions,
- Educate youth on evidence-based solutions and,
- Cultivate awareness and trust in the efficacy of evidence-based treatments and delivery systems.

The AIM Ideas Lab models a research practice partnership to address the pressing need for mental health intervention and education among teenage youth at risk for depression, anxiety, and suicidal thinking, while directing lived experience in mental health concerns to the attention of researchers dedicated to overcoming these challenges. The AIM Ideas Lab will curate scientific inquiry among teens, in collaborative response to published scientific research and researcher-led discussion of youth mental health topics. There will be an emphasis to present on youth mental health studies with trial participants that reflect the demographic of the Ideas Lab cohorts.
Participating students (ages 14-18) will collaborate in a small group setting to:

- ignite student advocacy for mental health solutions; exploring evidenced based youth mental health research,
- ideate on the most pressing mental health issues and formulate questions they would like researchers to answer,
- elevate youth voices in mental health research priorities.

<u>Deliverables / Executable Service</u>
The Ideas Lab will catalyze entrepreneurial thinking amongst students, serving up to 250 Monterey County High School students within a 10 hour program hosted over 8 weeks.
Program recruitment begins in the Fall 2021 with Lab cohorts hosted in the Spring 2022.
Student participants will include those in underserved communities hardest hit by the COVID pandemic, having an increased need to access mental health support services.
Delivery of curriculum may be in person or virtually. All program material will be accessible online. Depending on funding, participants may have the opportunity to leverage sponsored access to web and mobile applications and devices to support their mental wellness practice. Parents and teachers of participants will receive access to mental health first aid training as an intervention component to support the teen participant on-going.
<u>Ideas Lab Curriculum Outline</u>
Week 1: Course Overview & Introduction
Week 2: Researcher, Local Mental Health Specialist, & Mental Health Resources Presentations/Panel
Week 3: Researcher, Local Mental Health Specialist, & Mental Health Resources Presentations/Panel
Week 4: Researcher, Local Mental Health Specialist, & Mental Health Resources Presentations/Panel
Week 5: Introduction to Participatory Action Research & Student Projects
Week 6: Student PAR project development
Week 7: Student PAR project development
Week 8: Student PAR project development
Week 9: Student PAR project presentations
Week 10: Student PAR project presentations

The AIM Ideas Lab will maximize outcomes to uniquely build capacity and generate collaborative discussions with numerous Monterey-based healthcare specialists and mentors from youth serving organizations supporting the AIM Ideas Lab. This includes development of new channels for MCBH to

influence and increase mental health referrals in Monterey County among Spanish/ Latino community members.

Capacity Building with Mentorship

Students and participating teachers will be aligned with trained Ideas Lab program mentors from:

- California State University Monterey Bay
- Monterey Peninsula College
- Hartnell College
- Salinas Valley Adult Education Consortium
- Monterey Cadre Leadership Program
- CHOMP
- Montage-Ohana Mental Health
- Harmony at Home
- Community Partnership for Youth
- City Youth Councils

AIM will leverage its world-renowned Scientific Advisory Board (SAB), funded researchers, and network of mentoring partners to lead in safe, trauma-informed think tank sessions within teen cohorts. The AIM SAB will review the student submissions for questions needing scientific investigation and provide feedback/ constructive coaching to Lab participants. Insights gained in the AIM Ideas Lab will be made available for educators engaged in the program as well as MCBH stakeholders.

As one of only four U.S. based members of the International Alliance for Mental Health Research Funders (IAMHRF) focusing on youth mental health research, AIM will also share Lab insights with the Alliance to build upon their commitment to increase inclusion of youth engagement in mental health research at a national and global level.

Implementation

Mental Health Connect (MHC), a mental health education consulting firm, will design the program, deploy the pilot, and monitor student impact. AIM will fund the project (along with community supporters), promote the program, and aid MHC to align subject matter expertise (i.e. clinical researchers and mental health professionals) to deliver the educational aspect of the Ideas Lab sessions.

We propose the AIM Ideas Lab will:

● Transform students' understanding of the relationship between scientific research, treatment for mental health disorders, and practices of mental wellness in all youth participants

● Empower High school students suffering from post-traumatic stress disorder (due to pandemic) and/ or related symptoms to have access to scientific experts, well-trained specialists in the community, and self service resources.

● Increase the desire to seek treatment as a result of decreased levels of stigmatization and discrimination, encouraged by youth program participants.

● Monterey County mental health specialists (counselors and therapists) as well as non-specialists (educators and college level mentors) have access to adequate capacity development opportunities that enable them to provide high-impact student engagement.

● Build youth mental health research priorities pipeline

● Pilot model to scale on-going PAR / Research Practice Partnership

The AIM Ideas Lab is a new, unique pilot program to Monterey County, as there's no similar program addressing youth mental health using the proposed YPAR and researcher-practice partnership approach.

AIM is aware of one established collaborative research-practice partnership among Alisal High School students of Monterey County and UCSC researchers from the Genomics Institute of Office Diversity in Santa Cruz County, however, this program focuses on STEM education, with zero mental health components.

Communication and Engagement Strategy
AIM has partnered with Mental Health Connect (MHC), a Monterey County based consulting and teaching organization specializing in inclusive mental health education.
MHC will support program design, recruitment, delivery of all Ideas Lab cohort sessions, and program evaluation.
The Ideas Lab will be hosted via virtual meetings using video conferencing and online collaboration tools.
All content will be available online.
The Ideas Lab will engage with up to 250 Monterey County High School students within a 10 hour program hosted over 8 weeks.

AIM Youth Mental Health has already received Ideas Lab participant interest.
Program recruitment begins in the Fall 2021 with Lab cohorts hosted in the Spring 2022.
We will leverage our community partners, including Monterey County's School District Superintendent and High School Principals to promote the pilot program for participant registration.
About Mental Health Connect
MHC is dedicated to guiding the shift in schools and non-clinical organizations with integrating and providing inclusive youth mental health environments.

Evaluation Plan
As part of the program assessment, Ideas Lab participants will provide their feedback at the start and finish of the program. This assessment will inquire on the likelihood of that individual to seek and receive mental health treatment if needed, and identify if a shift in this likelihood took place during the Ideas Lab. Other measurable insights from Lab participants, pertaining to attitude and trust in accessing mental health care and direct feedback into the teen population's belief in what's needed to overcome barriers and challenges in mental health care access, can be provided for MCBH and other Monterey County mental health stakeholders.

Measuring Success Outcomes
The following measurements will be captured via Lab participant assessment and overall program activities:
Population Health Assessment
- Stress level
- Mental health
- Physical Health symptoms

Engagement in Program
- Attitudes and understanding of mental health and research
- Lived experiences in mental health disorder

Youth Initiated Research Proposals
- Pipeline of qualified research questions

The Ideas Lab will host a training on mental health first aid from the National Council for Mental Wellbeing to serve as a skills based course for parents and school educators of Lab participants, in helping to develop an inclusive support system to address mental health and substance use matters. The participation in mental health has the potential to influence trust in the outcomes of seeking mental healthcare. It is also possible to promote paths to seek treatment as proposed by MCBH.

How many individuals to you plan to serve or reach with your micro-innovation activity? 300

How many individuals do you plan to refer to mental health services? 50

Timeline
The AIM Ideas Lab timeline:
- August 2021 through October 2021 - Curriculum design
- October 2021 through February 2022 - Program recruitment
- March 2022 - May 2022 - Ideas Lab cohort sessions are live
- June 2022 - July 2022 - Evaluating and sharing of YPAR insights with community stakeholders

Round 6

Majesh Natrajan

Our innovation project "Heal" introduces holistic, mindfulness-based sound meditation treatment practice in Monterey County aimed at relieving symptoms of mental health issues. We do this with an immersive on-demand multi-sensory meditation pod like structure, called "Heal"

Heal uses sound therapy as the “training wheels” as foundation for a strong long term meditation practice that enables participants to be mindfully engaged. The intervention is aimed at relieving stress, depression, feelings of detachment, coping skills, irritability, anxiety and physical pain, and can be integrated into Monterey County’s prevention and intervention programs to address and/or supplement treatments for a range of mental health symptoms and concerns Heal can also aid in relapse prevention, recidivism prevention and help with reentry.

Additionally, this can help the community with early prevention of onset mental health concerns. Heal is an effective, adoptable, and sustainable treatment that can help reverse the growing upward trend of mental illness in Monterey county over time.

In terms of form factor, Heal is a physical sound space with a footprint of roughly 3 feet by 3 feet that takes about 2 hours to fully install. The participant sits on a (cushioned) bench inside the "Heal Pod", which plays short 3-20 min audio pre-recorded orchestrated sequence of therapeutic sounds. These sound meditation sessions are designed to boost immune levels & functions (Trends in Cognitive Sciences April 2013, Vol. 17, No. 4 pg. 187, 188), help in coping with stress, depression, feelings of detachment, irritability, anxiety, and physical pain. It is highly recommended that participants are consistent with the use the Heal Pod 2-3 times a week with each session lasting 12-20 minutes and leaving 10-15 mins post-meditation to document and journal in the questionnaire form provided for a minimum total time period of at least 6 weeks. The weekly frequency and per session duration can be increased and the specific meditation tracks recommended over time in consultation with participants’ therapist. As the participants get deeper in their practice, the duration of each session

can also be increased from 12- 20 minutes to one-hour meditation sessions.

Heal is designed to maximize the experience of being part of this testing method and intervention as opposed to 'learning' any other form of mindful meditation in that the results provided indicate a level of stress reduction that does not require the individual to learn a disciplined form of meditation. There is a passiveness approach to this engagement that reduces barriers to first-time and skeptical participants.

These sounds envelope the patient in 360 degrees soothing surround healing music, getting them to a stress free, happy and comfortable state of mind almost immediately; much like the vibrational happiness infants experience inside the womb of their mother, or while listening to classical music.

The benefits of Heal sound meditation session extends beyond the time they spend inside the Heal pod to help them continue with their day being a little calmer, collected, and better prepared to cope with stressful situations.

The Heal experience is designed to be used with a curriculum that has been created and curated with clinical psychologists and therapists in the medical field and recovery centers. The therapists will work with participants and use journals, questionnaires and group discussion to assess the participants engagement and results from each of the Heal session.

The curriculum, much like a classroom curriculum with measured outcomes, for the Heal includes:

- Verbal intake & introduction to the concepts of the Heal and sound meditation. (There is an introduction 15min meditation track that walks the patient through what to expect, do's and don'ts, and how to get the most out of each session)
- One-time scheduling of 3 sessions a week for 3-20 mins each Short 5-7 min self-evaluation after each session.
- Weekly/monthly review of the wellness forms to track progress on how this has affected their life's daily outcome with a counselor
- "End of program" evaluation with counselor (exit interview).

The purpose of the curriculum is to enable both the participants and the county to track and assess the participant's responses to treatment made week over week. This way any expected outcomes established at the beginning can be evaluated at exit from the jail system.

This curriculum is template driven that can be easily customized to a given participant given their needs for the treatment plan and specific disorder being treated.

Appendix D: Project Evaluation Reports

Round 4

Michael Houston/Greenfield Cultural Arts Events Outreach

Final Report
Mi Vida, Mi Arte, Mi Alegria South County - June 2021 - June 2022

MIG2- Houston Background & Purpose

Mi Via, Mi Arte, Mi Alegria South County (MIG Houston 2) was designed to address the Monterey County Health Department's Behavioral Health Branch gap in services provided to Latino populations by using community artist performers to share experiences to counter attitudes of the stigma associated with mental health issues with recognized community artists promoting access to mental health services in a safe family-appropriate environment. Surveys track community attitudes and provide the County with data to improve its outcomes. Project leads receive an orientation and experience from the project to go forward with sufficient knowledge and means to provide referrals to community services including school counselors, Interim Inc housing, Sun Street intervention, Partners for Peace parenting, Catholic Charities service, and online support groups, and Blue Zone lifestyle workshops.

The program's outreach used face-to-face contact with collaborating organizations' digital media to promote the events. AMP Media and Alegria Musical en Radio y TV will broadcast and produce videos carrying the message of the project in Spanish.

Project leads worked with First Night Monterey, Greenfield Cultural Arts Center, National Steinbeck Center, Patriot Park, Greenfield, and Sol Treasures in King City to present programs in Spanish which was recognized by partners and community leaders as an important part of returning live relevant art to the Oaxacan and Spanish-speaking community in South County.

a. The project audience and presenters consisted of Oaxacan and Spanish-speaking farmworkers, and individuals residing in Monterey County in Salinas, Greenfield, and King City.
b. The live performances let artists share their lived experiences with mental health challenges and recovery.
c. The events hosted Interim Inc, Blue Zone, Catholic Charities, and Lideres Campesinas to dialogue on mental health and mental health resources with attendees during and following performances.
d. Host facilities and local performing groups made it clear to attendees that they were prepared to provide appropriate mental health resource referral information to attendees. The events were documented extensively with video and stills.

Attendees filled out surveys asking for demographic information regarding ethnicity, age, gender, arts as healing, unhappiness, anger issues, disorientation, the relative values of speaking with people in confidence, the value of social services in Spanish, and the value of a safe place to talk. The purpose of the survey was to assist them in determining if they should seek service referrals for mental health services for themselves, their friends, or their families.

Presentation Report
1. October 30, 2021-Greenfield Cultural Arts Center First Night Monterey and Mi Vida, Mi Arte, Mi Alegria Day of the Dead.

a. Number of attendees: 50-60.

b. Content of workshop performances: held outdoors with an introduction to the project by the coordinator and Greenfield Lyricist Andrés Hernandez. Performers included Arcoiris Cultural Folklorico, Greenfield High Choral Trio, and ranchera singer Alex Sings.
c. Content of dialogue with audience: Greenfield High School Music Teacher stresses the value of art as healing especially coming out of Covid lockdowns. Folklorico instructor stresses the value of joy in dance and the importance of artistic social activities for children. Alex Sings promoter shares how his music saved him from depression after an injury as a farmworker in Greenfield. The coordinator invites everyone to more presentations promoting art as healing and accessing social services when you need them.
d. The presentation offered an open invitation for the audience to get referrals through school counselors and Greenfield Art and Culture Center instructors.
e. The project doesn't provide social workers at events to get an immediate number of individuals reporting attending or attempting to attend referred service. Mental health intervention through the arts is an incremental consciousness-raising transformational learning process that leads one to make better life choices in pursuit of happiness.
f. Andrés Hernandez approaches participants and the audience members one-on-one as someone whose substance abuse after an accident in the fields almost destroyed his life. Alliance on Aging helped him get the help he needed.

Presentation Report
2. March 31, 2022, National Steinbeck Center Cesar Chavez Make a Difference Day
a. Number of attendees: 20
b. Content of workshop performances: Poetry by Josefina Garcia. Songs and poems by Andres Hernandez. Comments on art as intervention and the value of social services.
c. Content of dialogue with audience: Poet Josefina Garcia shares her book on her lifetime of struggle as immigrant farmwork and businesswoman to achieve fulfillment in collaboration with the United Farmworkers and Salinas Living Poetry and Prose Project. She tells how she was assisted by Rosa Elena, a poet whose help from BHS helped her to deal with her undiagnosed mental issues and become Josefina's mentor. Andres Hernandez shared his songs and poems and how Alliance for the Aging's Irene Valverde got him the help he needed and connected him with Salinas Living Poetry and Prose Project to publish seven books of his poems, cumbias, rancheras, etc.
d. Number and type of referrals provided: The presentation offered an open invitation for the audience to get referrals through school counselors and Greenfield Art and Culture Center instructors.
e. Number of individuals reporting attending or attempting to attend referred service(s). The project doesn't provide social workers at events to get an immediate number of individuals reporting attending or attempting to attend referred service. Mental health intervention through the arts is an incremental consciousness-raising transformational learning process that leads one to make better life choices in pursuit of happiness.
f. Qualitative remarks: The comments by Josefina and Andres speak to the value of art and support to bring someone to get the help they need. In Rosa's case getting her poems published in Voces de la Calle changed her life and led her not only mental health support, but housed a AA degree from Hartnell, four published poetry books, and confidence to become an activist against sex trafficking.

Presentation Report
3. May 15, 2022, Fiesta de las Madres, Patriot Park, Greenfield
a. Number of attendees: 70 41 Surveys filled out.

b. Content of workshop performances: MCs Andres Hernandez and Pilar Mendoza, Folklorico dance by Arcoiris Cultural, mariachi music and songs by Mariachi Juvenile Jaliscience, poetry and song by Josefina Garcia, songs with live mariachi ensemble by Alex Sings and Patricia Alejandres. Comments on art as intervention and the value of social services. Raffle for prizes and a refurbished computer donated by Loaves, Fishes, and Computers.

c. Content of dialogue with audience: Pilar Mendoza introduces the program with a reminder of how important the arts are and social services for those who need them. Andres Hernandez greets friends in the audience from his days as a youth soccer coach and how art and social services have helped him through troubles.

d. 50 attendees filled out surveys asking for demographic information regarding ethnicity, age, gender, arts as healing, unhappiness, anger issues, disorientation, the relative values of speaking with people in confidence, the value of social services in Spanish, and the value of a safe place to talk. The purpose of the survey was to assist them in determining if they should to seek service referrals for mental health services for themselves, their friends, or their families.

e. The presentation offered an open invitation for the audience to get referrals through school counselors and Greenfield Union School District Counselors, Greenfield Art and Culture Center instructors. and Greenfield Science Center Staff. Mental health intervention through the arts is an incremental consciousness-raising transformational learning process that leads one to make better life choices in pursuit of happiness.

f. Qualitative remarks: The group's decision to celebrate a traditional Mexican Mothers Day celebration in the park was seen as an example of the community reclaiming their culture and art as we move through Covid. Survey comments referred to the ambiance, "Knowing my culture." "Walk and talk about feelings."Benefits for my autistic daughter."

Presentation Report

4. May 22, 2022, Free Music, Poetry, and Songs in the Park, Patriot Park, Greenfield

a. Number of attendees: 65

b. Content of workshop performances: MCs Jorge Flores and Pilar Mendoza, Folklorico dance by Arcoiris Cultural, Poetry and song by Josefina Garcia, poetry and song by Josefina Garcia, Mixteca and Spanish poetry by Jorge Flores, live music and Oaxacan "chilena" dance mix by Daniel Rubio. Spanish language comments on art as an intervention and the value of social services by Pilar Mendoza and Jorge Flores which included a ten-minute piece on accepting his Oaxacan heritage after growing up in Tiajuana. Raffle for prizes and a refurbished computer donated by Loaves, Fishes, and Computers.

c. Content of dialogue with audience: Pilar Mendoza introduces the program with a reminder of how important the arts are and social services for those who need them and the value of more boys taking up Folklorico dance. Jorge Flores talks about the transformative value of becoming yourself, transformative learning through art, and the value of social services that have helped his friends and family.

d. 50 attendees filled out surveys asking for demographic information regarding ethnicity, age, gender, arts as healing, unhappiness, anger issues, disorientation, the relative values of speaking with people in confidence, the value of social services in Spanish, and the value of a safe place to talk. The purpose of the survey was to assist them in determining if they should seek service referrals for mental health services for themselves, their friends, or their families.

e. The presentation offered an open invitation for the audience to get referrals through school counselors and Greenfield Union School District Counselors, Greenfield Art and Culture Center instructors, and Greenfield Science Center Staff.

f. Qualitative remarks: The group's decision to celebrate and dance to traditional Oaxacan music in the park as we move through Covid. Survey comments referred to the ambiance, "Music, Sun,

Park." The Greenfield police enjoyed talking to the presenters and the audience. Interim joined us again to help with surveys and raffle activities as well as information on how to get referrals to their mental health services.

Presentation Report

5. June 5, 2022, Free Music, Poetry, and Dance for the Whole Family

a. Number of attendees: 40. 34 surveys filled out

b. Content of workshop performances: MCs Jorge Flores and Pilar Mendoza, Folklorico dance by Arcoiris Cultural, Mixteca and Spanish poetry by Jorge Flores, live music and Oaxacan "chilena" dance mix by Daniel Rubio. Spanish language comments on art as an intervention and the value of social services by Pilar Mendoza, Michael Houston, and Jorge Flores. Raffle for prizes frame art.

c. Content of dialogue with audience: Pilar Mendoza introduces the program with a reminder of how important the arts are and social services for those who need them and the value of more boys taking up Folklorico dance. Jorge Flores talks about the value of social services, which have helped his friends and family. Michael Houston called everyone's attention to the Art as Intervention mural for the Art as Intervention at the Youth Center. He noted that the mural project has greatly reduced recidivism among incarcerated youth who are turning their lives around. He reminded parents that school counselors are there to assist them to get help when their family needs it. The raffle included culturally relevant art pieces.

d. 34 attendees filled out surveys asking for demographic information regarding ethnicity, age, gender, arts as healing, unhappiness, anger issues, disorientation, the relative values of speaking with people in confidence, the value of social services in Spanish, and the value of a safe place to talk. The purpose of the survey was to assist them in determining if they should seek service referrals for mental health services for themselves, their friends, or their families.

e. 34 attendees filled out surveys asking for demographic information regarding ethnicity, age, gender, arts as healing, unhappiness, anger issues, disorientation, the relative values of speaking with people in confidence, the value of social services in Spanish, and the value of a safe place to talk. The purpose of the survey was to assist them in determining if they should seek service referrals for mental health services for themselves, their friends, or their families.

f. Qualitative remarks: As always, the Probation Department 6 x9 mural of Elkhorn Slough made a great backdrop to the event. Sol Treasures staff and volunteers and My Life, My Art, My Happiness leads helped with surveys and raffle tickets. Presenters and leaders spoke with individuals and family groups about arts and the benefits of help from social services. with the warm and friendly environment of the backyard concert. They also answer questions on how to get referred to social and mental health services.

Presentation Report

6. June 12, 2022, Ranchera Singers and Poetry at Sol Treasure King City

a. Number of attendees: 35

b. Content of workshop performances: MCs Andres Hernandez and Pilar Mendoza, Folklorico dance by Arcoiris Cultural, mariachi songs performed by Patricia Alejandres, Carlos Rodriguez, and Juana Rojas, poetry by Josefina Garcia. Comments on the value of friendship and family support and art as intervention and the value of social services. The raffle for prizes included framed regional photographic art and items from the Sol Treasures shop.

c. Content of dialogue with audience: Pilar Mendoza introduces the program with a reminder of how vital the arts are and social services for those who need them. Andres Hernandez greets friends and introduces the performers who will perform the songs he wrote when he was in prison and since. Social services have helped him through troubles.
d. 27 attendees filled out surveys asking for demographic information regarding ethnicity, age, gender, arts as healing, unhappiness, anger issues, disorientation, the relative values of speaking with people in confidence, the value of social services in Spanish, and the value of a safe place to talk. The purpose of the survey was to assist them in determining if they should seek service referrals for mental health services for themselves, their friends, or their families.
e. M The presentation offered an open invitation for the audience to get referrals through school counselors, Rosemary Soto of the Health Department at 620 Broadway St # N, King City, (831) 386-6899
f. Qualitative remarks: Sol Treasures was a very hospitable site and looks forward to doing more community building, fun, and healing through the arts both in King City and throughout the county with art, music, and friendship.

Appendice – Survey Results
153 attendees filled out surveys.

Ethnicity
24 No answer, 112 Mexicano/Mexicana, 44 Latin American, 8 Indigenous, 6 White

Age in Years
57 No answer, 17 0-12, 7 13-20, 25 21-35, 38 36-and up

Gender
54 No answer, 55 Female, 39 male

1. Would you come to another Mi Vida, Mi Arte, Mi Alegria Presentation?
3 No Answer, 141 Yes, 2 No

2. Do you have friends or family that are very unhappy?
32 No Answer, 35 yes, 86 no

3. Do you have friends or family that are quick to anger?
27 No Answer, 44 Yes, 72 No

Do you have friends or family that have mixed up feelings or thinking?
No Answer 27, 35 Yes, 84 No

What would make them feel better?
4. Talking with people they trust.
47 No Answer, 114 Yes, 0 No

5. Help in Spanish with Social Services
73 No Answer, 82 Yes, 0 No

Would you invite other people to My Life, My Art, My Happiness Programs?
8 No Answer, 144 Yes, 5 No

Door to Hope/'Circle of Security' Program for Farmworkers

Door To Hope
Micro-Innovation Grant 2021-2022 Circle of Security

B. Project Summary Report:

a. Total number of participants: 32 total participants.

b. Demographics of total number of participants: All participants were of Hispanic/Latino descent. 22 participants were of Indigenous descent (19 Triqui and 3 Mixteco).
18 were South County residents, 11 from Salinas, 2 from Marina, 1 from Sand City.
22 spoke an indigenous language as their primary language (19 Triqui and 3 Mixteco)
10 participants spoke Spanish as their native language
All participants were of low socio-economic status
A majority of participants were farmworkers
3 participants had an open CPS case
4 fathers participated consistently

c. Total number of MH referrals provided to participants: 12 referrals were made to mental health services. Referrals were made to MCBH through the Access Line (3 referrals), Community Human Services (6 referrals made specifically for their non-insured MH program), Beacon Health (1 referral), DTHs Behavioral Health Integrated Program (1 referral) and a private insurance provider (1 referral).

d. Type of referrals provided to participants: Aside from the 12 referrals made directly to mental health services Florentina (case manager) made referrals to other parenting programs such as the F5 Collaboratives, community playgroups, Abriendo Puertas, Positive Discipline and Parents As Teachers. She also referred to CHISPA, MC Housing Resource Center, MC Food Bank, local food distribution, diaper drives, MAOF (childcare), Go Kids (childcare), and financial assistance resources such as United Way 211, and national programs providing financial support.

e. Number of participants that utilized referrals (e.g. attended at least one appointment)
9 participants were successfully connected to mental health services and continue to regularly see their therapist.

f. Description of successes, challenges and barriers associated with this project, in relation to the stated goals of promoting greater access to mental health services by unserved and underserved Hispanic/Latino communities, and contributing to statewide learning under the Innovations component to identify potential promising practices. (i.e. If this program was regularly offered to this population of focus, would it contribute towards improved/positive perceptions of mental health services, and/or promote greater help-seeking behavior? And, what else was learned as part of this project that can inform mental health services in becoming more culturally responsive and engaging for these unserved and underserved populations?)
Successes in meeting goal:

Offering Circle of Security classes to the unserved and underserved Latino communities was a fundamental way to begin exploring basic mental health components and information with a population that has limited access to mental health education or resources. We found that when parents understand what positive relationships look like and are able to learn about their own traditional mental health knowledge and practices they are then able to connect their experiences to their needs and better understand the resources available to them to address such needs/challenges.

This leads to another success we had in meeting the goal. By offering COS to families of different cultural backgrounds (Mexican, American, and Indigenous) we were able to explore the many ways in which different communities engage with their mental health needs and wellbeing. Because COS first explores what a person already knows or has experienced around positive relationships, we were able to learn the different practices parents already use to process mental health challenges. For example, we learned that the Triqui community historically participates in "sweat lodge" like rituals when needing to heal their body and spirit. They also have leaders that guide a person through going back to painful memories or experiences that "robbed" them of their positive spirit and process those negative experiences to bring their positive spirit back to them. Together we learned that all cultures and communities already have mental health ideas and rituals and now need spaces in their new communities in Monterey County to practice their native traditions that help them heal their mind and body. When people have resources in their communities that reflect who they are and where they come from they are more willing to accept help and support when they need it.

This program works because it not only respects cultural differences but it allows adaptations to incorporate unique cultural values, learning practices, and traditions to guide parents in reflecting on their own ideas about relationships and mental health and come up with their own goals and objectives for their own families.

All of these successes were possible because we were able to offer services to families in their own language and using culturally appropriate methods of learning such as storytelling and visual aids. Both Triqui speaking groups shared having a very positive learning experience as they listened to new information in their own language and were able to discuss, reflect and ask clarifying questions in the language they felt most comfortable in. Having groups specifically for Triqui speaking families helped create a safe and comfortable environment where parents felt safe to speak and become vulnerable enough to reflect and connect with new ideas and information. Parents shared feeling connected to other parents from their same communities and able to learn from each other because they understood where they were coming from.

In an ideal setting, COS would be offered consistently and permanently throughout the county all year long, specifically in the most isolated and underserved parts of the county, and offered in the many languages spoken in our county and facilitated by members of those specific communities. Classes would ideally be in person, with virtual options available during the agricultural season, and include free child care and meals.

COS would be a great way to create more positive and inclusive spaces for our communities to learn about their own relationships with mental health and wellbeing and together reflect on their needs and ability to reach out for support when needed. We can then work together to assure that our systems of care include mental health services and treatments that address the unique needs of our diverse communities. When families have a better understanding of their needs and see services in their communities that value their history and traditions they will be more able and willing to seek out help when needed.

COS is also the perfect venue for our systems of care to learn more about the needs of each community we set out to serve. First we must understand where people come from to understand the root of their behavior. We cannot expect people to simply accept our services when 1. our services do not cater to their

language, culture, location, etc. and 2. our services do not understand or value the knowledge and practices they already have to address their wellbeing. When we create a health system that creates spaces inclusive of and tailored to the specific needs of all of the different cultural sectors of our county we will automatically foster a community of help-seekers that trust in and understand the services available to them.

This project helped us realize that as a system we must first invest in educating ourselves on the needs of those we are trying to recruit and serve. Creating safe and reflective spaces to have open and vulnerable conversations helped us learn about the people of our community and understand that our Western ideas of mental health treatment will not work with all populations. It helped us see that almost all cultures already have their own mental health practices and treatments that we know almost nothing about. We need to start there. Instead of investing resources in recruiting and trying to convince everyone that our services are the answer to everyone's mental health challenges, we must invest in learning more about what our communities already do and need to promote their own wellbeing. We must invest in the education and leadership of culturally congruent leaders that can lead the implementation of culturally responsive mental health treatments all over Monterey County. Our county residents already know what they need, we must listen to understand those needs and provide the culturally specific treatments and services that promote healthy and productive lives.

Circle of Security Session 2 Report

a. ***Meeting Details***

The Circle of Security Program is an eight-week session class that began on January 19, 2022 and ended on March 9, 2022. The Circle of Security concept focuses on parenting attachment and creating positive relationships. Sessions were provided via zoom once a week for two hours, Wednesdays from 12:00pm to 2:00 pm. Attendance sheet attached.

b. ***Number of participants***

7 parents participated for 2 or more sessions. All participants were connected to multiple agencies, including mental health services, by the Care Coordinator Florentina Sanchez. Florentina connected with all participants outside of the COS session to address individual family needs and connect to county-wide services.

c. ***Demographics of participants (consistent with MHSA regulations)***

All participants reside in Greenfield and all are of Oaxacan Indigenous decent. All participants speak Triqui as a primary/native language.

d. ***Methods of participant recruitment***

Fliers and referral forms were shared with partner South County agencies such as Centro Binacional Para el Desarrollo Indígena Oaxaqueño, Monterey County Probation Department (CAP), GUSD, as well as Door To Hope programs such as the DTH/F5 Collaborative and the Behavioral Health Integrated Program (BHI) to reach parents from the native Mexican communities whose first language is Triqui Of Copala. Fliers were also distributed to county wide agencies such as MCBH, AUSD, Go Kids, MCHD, etc.

Fliers and referrals were created in English and Spanish as there is no Triqui written language. An image of an indigenous family was highlighted on the flier to illustrate positive parent-child engagement/attachment. Fliers and referral forms attached.

e. ***Number and type of mental health service referrals provided to participant (referral utilization information to be included in Project Summary Report)***

Two moms were connected to Community Human Services for Mental Health services. CHS is the only agency in the county who accepts and provides MH services for the undocumented population. Their services are limited to English/Spanish and only at their Salinas offices.

f. ***Summary of successes***

The biggest success with this COS session is creating a space for indigenous/immigrant families to not only learn our western ideas and practices around mental health but most importantly, for us as providers to learn more about what our communities already know about mental health and what they already practice within their own cultures to support their own and their families' mental health and spirituality. We learned so much from reflecting on universal parenting practices and how these parents connect with their children and what they do when they become overwhelmed and stressed. The facilitators created a space where the parents were the experts on their own children and families and this class supported them in reflecting on these practices to determine what worked and what they wanted to improve upon. Parents felt respected and able to share their strengths and practices because the COS framework is based on valuing parents as they come and working with the knowledge they already have. The indigenous cultures already have a lot of spiritual practices that support their wellbeing. It is would be helpful for us as a community to learn more about what these are and support them in creating spaces for them to continue their rituals and practices they left behind. Being able to participate in their own cultural traditions, such as sweat lodges and traditional art, can assure they are constantly taking care of their own mental health and wellbeing in their own ways. Spaces like COS allow us to learn from each other and together come up with creative and culturally appropriate ways indigenous families can pull from their strengths and values to stay true to themselves while also learning how to meet the needs of their children. All participants were open to learning more about attachment and building healthy relationships with their children, which are concepts that can be adapted to the specific cultural values of different communities. We would love to continue creating these types of reflective and respectful spaces where our different communities come together to learn from each other, instead of one party sharing what we may think is the "medicine" to mental health challenges.

This session the facilitators confirmed that a smaller more intimate group is crucial to create a safe space where parents built trust and vulnerability amongst each other and felt comfortable sharing personal and sensitive information with each other while reflecting on the information presented. COS International recommends no more than 10 parents in a session and with 7 parents in this session the facilitators felt all parents participated regularly and shared feeling safe and supported by other parents when sharing and asking questions. This is even more important when facilitating a virtual class as it takes more time to build trust and to feel connected to those on the screen.

Parents shared they appreciated being able to ask questions and express themselves in their native language. This assured that they really understood the information that was being shared and were able to then apply it to their own lives. They reported that Mental Health was a topic that they do not learn about or discuss with family or friends and it was essential that they first learn about it in their native language to be able to fully grasp the new concepts and ideas. The presentations were also infused with visuals and videos as many of these families have limited Spanish and are illiterate. Florentina also changed some of the presentation verbiage to include words, phrases and saying commonly used and understood by this community.

Having the class virtually allowed them to be more consistent as they did not have to worry about leaving their home and all of the challenges that come with that, including getting kids ready etc.

Having two facilitators was helpful in many ways. They were able to help each other prepare for each session. They supported each other in starting conversations and engaging parents to join a conversation. One would take care of the zoom logistics and attendance while the other kept the session material moving.

Having a Care Coordinator was essential in being able to connect with each parent individually before or after each session. Florentina met with each parent before the start of the class to assure everyone had the ability to connect to the virtual class and delivered class materials. She then connected with them after each session to discuss what they had learned and to get to know each family individually to determine any potential needs for community referrals such as mental health, parenting or financial resources. Florentina would then assure they connected and were able to receive the services they needed. Florentina would follow up with resources when barriers arouse, such as assuring translation or transportation services.

g. ***Challenges and barriers:***

We scheduled the class in the morning as many families do not work in the agricultural off season (Nov-March). In early March, however, some of the participants returned to work and were not able to complete the class.

Several of the participants struggled to stay connected in the class as they used their cell phones and had limited bandwidth or internet data and were kicked off throughout the sessions. South County also has poor internet reception which made it difficult for all parents to stay connected, often having poor connectivity.

The biggest barrier we are encountering across our DTH programs, including COS, is the lack of mental health services to support the undocumented. Initially, at the beginning of the fiscal year, we were optimistic as CHS shared they had specific funding and therapists to provide mental health services to the undocumented population. We quickly referred several of our DTH clients, including two from COS, and their capacity quickly reached its limit. They then lost one of their clinicians and until now are no longer taking referrals. Both clients that were referred to CHS from this COS session remain on their waitlist. They are both in the mild-moderate category so neither MCBH nor Beacon can provide services.

Another barrier is the lack of Mental Health services in South County. Both moms referred to CHS live in Greenfield and do not drive. Their husbands do not support their participation in mental health services and will not drive them to Salinas for therapy. Unfortunately, CHS does not do home visits or have a location to provide services in South County. Both moms prefer in person services as their Spanish is limited and it is difficult to fully understand a Spanish speaker over the phone or virtual services.

Yet another barrier is the lack of services provided in indigenous languages. Interpretation/translation is also an issue. When initiating services with CHS they informed us that they were unable to translate consent forms as Triqui is not a written language and they did not feel comfortable interpreting when the family's grasp of Spanish is very limited. CHS is currently in the process of getting approval from MCBH to translate to non-English/Spanish speakers with the help of interpreters. Our COS clients remain on their waitlist for this reason. The limited knowledge we have about our indigenous communities and what their cultural values and practices around mental health and wellbeing are is a significant challenge. If we knew more about what they already do to address social and emotional challenges we might be able to support them in creating spaces for them to have access to more culturally congruent treatments. We must step away from the perception that therapy is the only solution for mental

health wellbeing and embrace the diverse treatments and practices that have been supporting families throughout the world from the beginning of time.

h. ***Any relevant information pertaining to participant satisfaction, and/or change in perception or understanding of mental health and mental health services***

The participants shared the following indicating that they were reflecting on and analyzing what they were learning in their COS sessions:

- "I used to yell at my daughter when she'll cry and she would cry even more, but now when I speak softly to her and try to understand her with questions, she'll calm down."
- "My daughter likes to explore a lot, I thought she was naughty but now I know she just wants to learn."
- "I've noticed that being present and supporting my child's exploration makes her feel happy and that makes her want to explore even more."

By sharing this we understood that participants changed their perception on how they acted before and how they are see now. They also opened up to us to share what they feared and the painful experiences that shaped them. As one of the clients shared; "I was detained by immigration when I crossed from Mexico to the United States. I was locked up for 3 months. During the first weeks I felt sad, worried and alone. I didn't understand anything of what was going on. I just knew I was in the hands of the green uniform people. In this place I found a group of Salvadorans who were also in the same situation as me. I didn't understand any word of what they were saying but with their action and sweetness of tones I felt accompanied in my feelings and made me feel calmer." pointing out her understanding of the importance of accompanying feelings.

"I have hate in my heart because of how I was treated as a child by my parents. And sometimes I feel like I'm doing the same with my children and I'm afraid of losing them."

"I can't control my anger. I scream at them without thinking first. Small things make me angry and I want to change my behavior to support my kids."

Creating a familiar and comfortable space for families to join helped in communicating new concepts and information. Families reflected on the new information and how it pertained to their own lives. They shared how they implemented what they were learning in their own homes and the progress they were seeing in creating more positive environments in their homes. Most parents wanted to continue learning about positive parenting/discipline information and asked for referrals to playgroups, Parent as Teachers, and our F5 Collaborative programs. Some were able to accept that they struggled in some areas and wanted to learn more about how mental health treatment could continue to help them explore their challenges and provide tools to address them. It was astonishing to see how when we begin by providing basic education and culturally responsive spaces for families to gather to reflect and discuss their own experiences most parents begin to seek out more support on their own. We must continue to empower all of our county parents as any type of treatment only works when the client fully understands its purpose and is committed to the process they understand.

Circle of Security Session 3 and 4 Report:

The third session was split into two as the number of interested participants exceeded the maximum amount of participants recommended by COS International. COS International recommends no more than 8-10 participants in zoom sessions.

Session 3 – Wednesday evenings from 4pm – 6pm via zoom. Started April 6, 2022 to May 25, 2022. Session facilitated in Spanish

Participants: 10 participants attended the first or second session. 8 participants attended regularly. Referrals were received from partnering agencies such as the Parents as Teachers program from Door To Hope and the Monterey County Probation Department's Child Abuse Prevention Advocacy Program (CAP).

Demographics: All participants spoke Spanish. 2 were bilingual Spanish/English and 3 was bilingual Spanish/Mixteco. 7 spoke Spanish as their primary language. All participants were of Mexican descent.
3 participants were of Indigenous descent.
6 participants were Salinas residents, 1 a Marina resident and 1 a Greenfield resident.

Methods of participant recruitment: COS fliers (attached) were emailed to Door To Hope agency programs as well as outside agencies and programs such as Centro Binacional, MC Probation Department, MC Children's Behavioral Health, F5 Collaboratives, MC Public Health Nursing, MC Parenting Connection etc. As a result, the partner agencies made 25 referrals. The high number of referrals was taken into consideration by splitting them to create an additional group that started on April 6, 2022 (Wednesday Classes). The split was done by following COSP curriculum recommendation of group sizes, which is a maximum of 8-10 caregivers in a reflection group.

Number and type of mental health service referrals provided to participant
All participants were given Mental Health education and resource information as well as connected to resources to support any area of their family wellbeing. This included additional parenting programs such as Abriendo Puertas and Positive Discipline.
1 participant was connected to Mental Health Therapy through her private insurance.

Summary of successes, challenges, barriers experienced during session
Most of these participants were parents with children approximately 7 to 11 years of age and had experience parenting. As parents continued with the class, parents shared that even though they had expertise as parents with older kids and toddlers, there are always things to open their eyes to. For example, one of the parents has shared that emotions were not spoken in the family that made him closed off to emotions but is now realizing how his lack of emotions is negatively impacting his children's emotional development. By providing COS classes to this group of participants it will enhance parents' knowledge that by not providing attachment to an infant or in early childhood will affect psychopathology of the infant or child throughout their lives.
Challenges: The participants in the COS class used their cell phones with limited data, which is not good enough to access the internet or videos. During the class participants were dropping and re-entering from the class as they lost and regained reception and/or data. Low internet data created misunderstandings and confusion in the COS sessions. Or sometimes they couldn't

connect because the internet was slow. At some point, the same thing happened with the facilitators where the internet was slow or had no connections.

Another challenge was that the COSP videos target parents of younger children and most participants in this group had older children and teens. Though the information still applied, it would be nice to include more videos that all parents can directly relate to.

***Session 4*:** Friday evening from 5pm-7pm via zoom. Facilitated in Spanish. Started April 1, 2022 and ended May 20, 2020. Sessions began from 4pm-6pm but were changed to 5pm-7pm as parents went back to work or increased the amount of hours they needed to work and were getting home later in the evening.
Participants: 9 participants began and ended this 8 week session. All referrals came from internal Door To Hope programs or partnering agencies.
***Demographics*:** 4 participants were from Salinas, 2 from King City, 1 from Greenfield, 1 from Marina and 1 from Sand City. 8 spoke Spanish as their native language, 2 were bilingual Spanish/English and one participant spoke Mixteco as their native language and Spanish as their second. 5 participants are agricultural farmworkers.
Methods of participant recruitment: Fliers and referral forms were shared with partner agencies such as Centro Binacional para el Desarrollo Indígena Oaxaqueño and the Monterey County Probation Department (CAP) as well as Door To Hope Programs such as the DTH F5 Collaborative and the Behavioral Health Integrated Program (BHI) to reach parents that are bilingual or monolingual Spanish speakers. As a result, the partner agencies made 25 referrals. The high number of referrals was taken into consideration by splitting them to create an additional group that started on April 6, 2022 (Wednesday Classes). The split was done by following COSP curriculum recommendation of group sizes, which is a maximum of 8-10 caregivers in a reflection group.
Number and type of mental health service referrals provided to participant:
All participants were given Mental Health education and resource information as well as connected to resources to support any area of their family wellbeing. This included additional parenting programs such as Abriendo Puertas and Positive Discipline. Basic resources were also shared such as the MC Food Bank, and the MC Housing Resource Center as well as the Salinas Adult School.
7 participants were connected to Mental Health services including MCBH, Community Human Service, Door To Hope's Behavioral Health Integrated Program, and Beacon Health.

Summary of successes, challenges, barriers experienced during session
The Circle of Security is a curriculum that heals, restores, and strengthens external and internal relationships based on reflections. In this curriculum, parents can reflect on the attachment of caregivers as essential for infants, toddlers, and preschoolers to develop. The caregiver's attachment is necessary for these inexperienced children to feel secure and explore the world, emotions, wisdom, etc. As parents learn the importance of attachment, caregivers recall memories of actions and decisions of daily life. They also explore parenting actions that can bring long-term results in the child's behavior in the future.
As caregivers feel safe and secure, caregiver's started to share stories related to the COS curriculum that brought them together; Stories such as painful memories of their childhood, overwhelming moments that caused ruptures in their relationships as well coping with the loss of a loved one and trying to protect a fragile child from emotional pain. COS helps parents reflect and modify parenting styles with children as well as helping parents forgive themselves for

things that they didn't realize was causing their children harm. As a result, this also increased the caregiver's awareness of the importance of showing empathy and positive attribution to their child.
Though some parents wanted to experience this class in person, it was helpful to have a virtual class as we were able to recruit families from throughout Monterey County. Families from all parts of Monterey County joined every week and were able to log on in their cars after work or from home without needing day care services.
Some of the challenges were pursuing parents for therapy services. Participants expressed their need for therapy by sharing stories of difficult times in their lives, creating an environment of mutual support. Barriers to being admitted to therapy services were the lack of time and fear of losing their job due to appointments with therapy services. Other challenges were unstable internet connections. The participants in the COS class used their cell phones with limited data, which is not good enough to access the internet. Low internet data created misunderstandings and confusion in the COS sections. Or sometimes they couldn't connect because the internet was slow. At some point, the same thing happened with the facilitators where the internet was slow or had no connections. Lastly was that the COSP video was not suitable for the participants. This is because the videos highlight the exploration of the circle of security from newborns to children. This conflicted with the ages of the participants' teens.

Any relevant information pertaining to participant satisfaction, and/or change in perception or understanding of mental health and mental health services

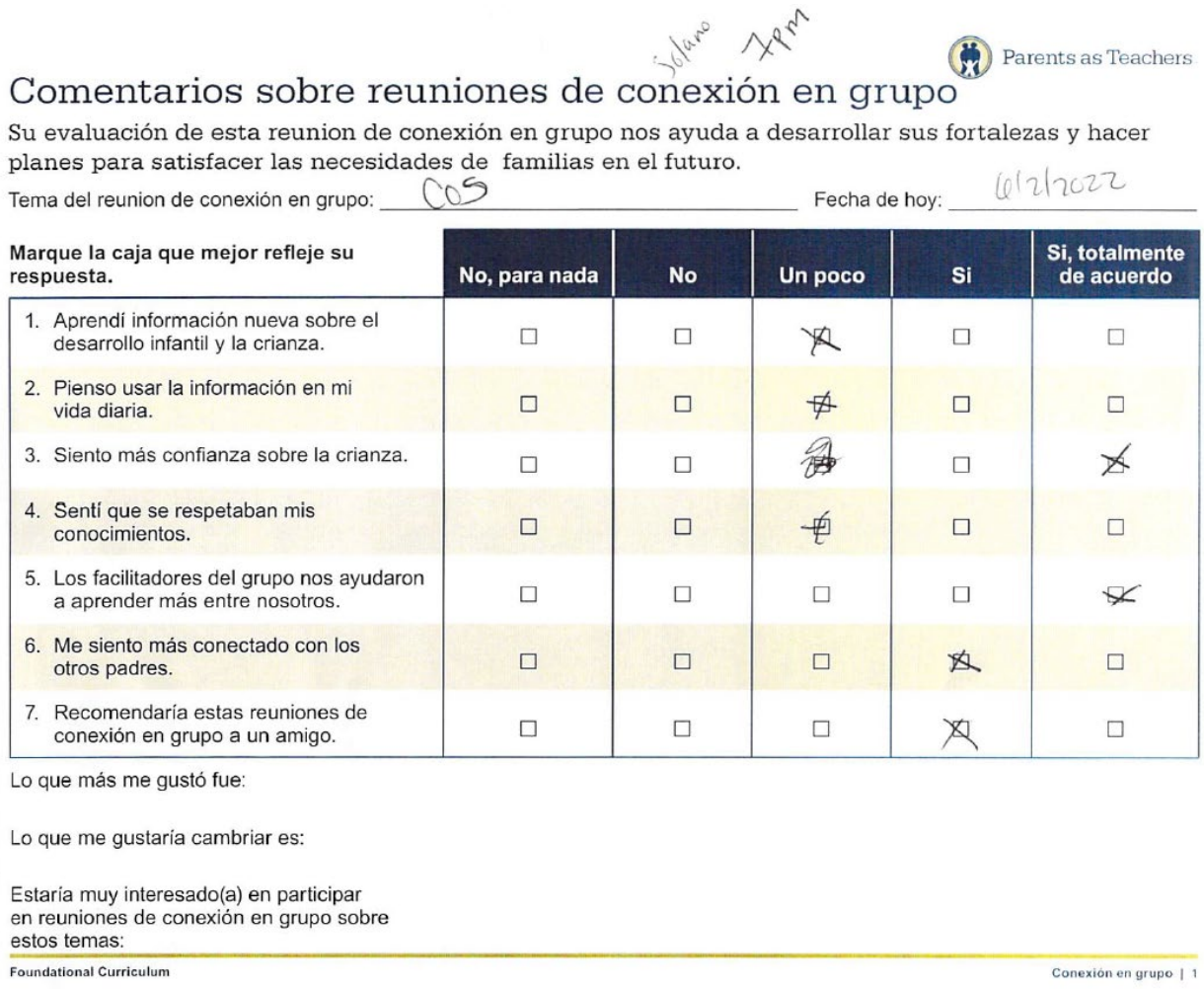
We have attached our parent satisfaction surveys that were completed with 12 participants a few days after both sessions ended. Here are some translated quotes from those surveys.

What did you enjoy the most from the COS Program:

"The conversations with other parents that are all going through the same experiences."
"That they made us feel very comfortable and they helped us learn"
"What I liked the most was the theme of wiser, bigger, stronger, kinder"
"How to talk to my kids"
"Everything. The theme of wiser, stronger, bigger, kinder. I learned the importance of analyzing and reflecting on my feelings and emotions. I am a person that gets mad easily. Now I analyze my feelings before responding."
"Everything they taught I liked"
"Emotions. I am more conscious of what I say and do with my kids"
"I learned how to connect and identify with other parents"
" I would like classes to be in person"
"I liked to learn about child development. I didn't know that when they play they are exploring."
"It would have been better in person but I did like it virtually as well."
We found that all parents were able to establish a sense of trust and safety and all participated by sharing their personal experiences and how they were personally connecting with the material presented. Because classes were relatively small participants got to know each other pretty well in eight sessions and all had ample time to share with the larger group or in small breakout groups.

Parents often shared their learning experiences. Many shared they had not been to a class such as COS where they were able to reflect on their own childhood experiences to understand why they

parent the way they do and understand where their values, ideas, and beliefs really come from. It was only then that they could better understand their needs. Many also shared how COS helps them reflect on their relationships with their children and all of the aspects that affect their relationships. They are then able to identify areas of growth that they want to focus on and learn strategies on how to improve their relationships with their children. They appreciated the ability to not only learn from the information the facilitators shared but most importantly from each other as they felt connected to other parents who were facing similar struggles.



Parents as Teachers

Comentarios sobre reuniones de conexión en grupo

Su evaluación de esta reunion de conexión en grupo nos ayuda a desarrollar sus fortalezas y hacer planes para satisfacer las necesidades de familias en el futuro.

Tema del reunion de conexión en grupo: COS Fecha de hoy: 6/2/2022

Marque la caja que mejor refleje su respuesta.	No, para nada	No	Un poco	Si	Si, totalmente de acuerdo
1. Aprendí información nueva sobre el desarrollo infantil y la crianza.	☐	☐	☒	☐	☐
2. Pienso usar la información en mi vida diaria.	☐	☐	☒	☐	☐
3. Siento más confianza sobre la crianza.	☐	☐	☒	☐	☒
4. Sentí que se respetaban mis conocimientos.	☐	☐	☒	☐	☐
5. Los facilitadores del grupo nos ayudaron a aprender más entre nosotros.	☐	☐	☐	☐	☒
6. Me siento más conectado con los otros padres.	☐	☐	☐	☒	☐
7. Recomendaría estas reuniones de conexión en grupo a un amigo.	☐	☐	☐	☒	☐

Lo que más me gustó fue:

Lo que me gustaría cambriar es:

Estaría muy interesado(a) en participar en reuniones de conexión en grupo sobre estos temas:

Foundational Curriculum

Conexión en grupo | 1

Parents as Teachers

Comentarios sobre reuniones de conexión en grupo

Su evaluación de esta reunion de conexión en grupo nos ayuda a desarrollar sus fortalezas y hacer planes para satisfacer las necesidades de familias en el futuro.

Tema del reunion de conexión en grupo: COS Fecha de hoy: 6/2/2022

Marque la caja que mejor refleje su respuesta.	No, para nada	No	Un poco	Si	Si, totalmente de acuerdo
1. Aprendí información nueva sobre el desarrollo infantil y la crianza.	☐	☐	☐	☐	☒
2. Pienso usar la información en mi vida diaria.	☐	☐	☐	☒	☐
3. Siento más confianza sobre la crianza.	☐	☐	☐	☒	☐
4. Sentí que se respetaban mis conocimientos.	☐	☐	☐	☐	☒
5. Los facilitadores del grupo nos ayudaron a aprender más entre nosotros.	☐	☐	☐	☐	☒
6. Me siento más conectado con los otros padres.	☐	☐	☐	☐	☒
7. Recomendaría estas reuniones de conexión en grupo a un amigo.	☐	☐	☐	☐	☒

Lo que más me gustó fue:

Lo que me gustaría cambriar es:

Estaría muy interesado(a) en participar en reuniones de conexión en grupo sobre estos temas:

Parents as Teachers

Comentarios sobre reuniones de conexión en grupo

Su evaluación de esta reunion de conexión en grupo nos ayuda a desarrollar sus fortalezas y hacer planes para satisfacer las necesidades de familias en el futuro.

Tema del reunion de conexión en grupo: COS Fecha de hoy: 6/2/2022

Marque la caja que mejor refleje su respuesta.	No, para nada	No	Un poco	Si	Si, totalmente de acuerdo
1. Aprendí información nueva sobre el desarrollo infantil y la crianza.	☐	☐	☐	☐	☒
2. Pienso usar la información en mi vida diaria.	☐	☐	☐	☐	☒
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6. Me siento más conectado con los otros padres.	☐	☐	☐	☐	☒
7. Recomendaría estas reuniones de conexión en grupo a un amigo.	☐	☐	☐	☐	☒

Lo que más me gustó fue: La Combersacion con otros padres que tabes estan pasando por lo mismo

Lo que me gustaría cambriar es: NO

Estaría muy interesado(a) en participar en reuniones de conexión en grupo sobre estos temas: Si

In Person

Parents as Teachers

Comentarios sobre reuniones de conexión en grupo

Su evaluación de esta reunion de conexión en grupo nos ayuda a desarrollar sus fortalezas y hacer planes para satisfacer las necesidades de familias en el futuro.

Tema del reunion de conexión en grupo: COS Fecha de hoy: 6/2/2022

Marque la caja que mejor refleje su respuesta.	No, para nada	No	Un poco	Si	Si, totalmente de acuerdo
1. Aprendí información nueva sobre el desarrollo infantil y la crianza.	☐	☐	☐	☐	☒
2. Pienso usar la información en mi vida diaria.	☐	☐	☐	☐	☒
3. Siento más confianza sobre la crianza.	☐	☐	☐	☐	☒
4. Sentí que se respetaban mis conocimientos.	☐	☐	☐	☐	☒
5. Los facilitadores del grupo nos ayudaron a aprender más entre nosotros.	☐	☐	☐	☐	☒
6. Me siento más conectado con los otros padres.	☐	☐	☐	☐	☒
7. Recomendaría estas reuniones de conexión en grupo a un amigo.	☐	☐	☐	☐	☒

Lo que más me gustó fue: Que nos hicieron sentir muy comodos y nos ayudaron a aprender. ☺

Lo que me gustaría cambriar es: Nada

Estaría muy interesado(a) en participar en reuniones de conexión en grupo sobre estos temas: Disciplina positiva, play group

Parents as Teachers

Comentarios sobre reuniones de conexión en grupo

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Tema del reunion de conexión en grupo: Cos Fecha de hoy: 6/2/2022

Marque la caja que mejor refleje su respuesta.	No, para nada	No	Un poco	Si	Si, totalmente de acuerdo
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7. Recomendaría estas reuniones de conexión en grupo a un amigo.	☐	☐	☐	☐	☒

Lo que más me gustó fue: La tema de grande, fuerte, Sabio y bondadoso mas me gusto fue la de X

Lo que me gustaría cambiar es: N/A

Estaría muy interesado(a) en participar en reuniones de conexión en grupo sobre estos temas:

Overphone

Parents as Teachers

Comentarios sobre reuniones de conexión en grupo

Su evaluación de esta reunion de conexión en grupo nos ayuda a desarrollar sus fortalezas y hacer planes para satisfacer las necesidades de familias en el futuro.

Tema del reunion de conexión en grupo: COS Fecha de hoy: 6/2/2022

Marque la caja que mejor refleje su respuesta.	No, para nada	No	Un poco	Si	Si, totalmente de acuerdo
1. Aprendí información nueva sobre el desarrollo infantil y la crianza.	☐	☐	☐	☐	☒
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6. Me siento más conectado con los otros padres.	☐	☐	☐	☒	☐
7. Recomendaría estas reuniones de conexión en grupo a un amigo.	☐	☐	☐	☒	☐

Lo que más me gustó fue: Como hablar con lo niños.

Lo que me gustaría cambiar es: NU

Estaría muy interesado(a) en participar en reuniones de conexión en grupo sobre estos temas:

On Phone

Parents as Teachers

Comentarios sobre reuniones de conexión en grupo

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Tema del reunion de conexión en grupo: COS Fecha de hoy: 6/2/2022

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7. Recomendaría estas reuniones de conexión en grupo a un amigo.	☐	☐	☐	☐	☒

Lo que más me gustó fue: Todo. Tema favorita. Ser grande, fuerte, sabio y bondadoso. Aprendí la importacia de analizar mis sentimientos ~~antes~~ emociones. – Era una persona que se enojaba rapido, Ahora lo analizo ante de expresarme.

Lo que me gustaría cambriar es: Nada.

Estaría muy interesado(a) en participar en reuniones de conexión en grupo sobre estos temas:

Over Phone

Parents as Teachers

Comentarios sobre reuniones de conexión en grupo

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7. Recomendaría estas reuniones de conexión en grupo a un amigo.	☐	☐	☐	☑	☐

Lo que más me gustó fue: Todo lo que enseñaron, Me gusto.

Lo que me gustaría cambriar es: No. Nada.

Estaría muy interesado(a) en participar en reuniones de conexión en grupo sobre estos temas: ~~Platformas~~

Parents as Teachers

Comentarios sobre reuniones de conexión en grupo

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Tema del reunion de conexión en grupo: 05 Fecha de hoy: 6/2/2022

Marque la caja que mejor refleje su respuesta.	No, para nada	No	Un poco	Si	Si, totalmente de acuerdo
1. Aprendí información nueva sobre el desarrollo infantil y la crianza.	☐	☐	☐	☐	☒
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7. Recomendaría estas reuniones de conexión en grupo a un amigo.	☐	☐	☐	☒	☐

Lo que más me gustó fue:

Lo que me gustaría cambriar es:

Estaría muy interesado(a) en participar en reuniones de conexión en grupo sobre estos temas:

Overphone

Parents as Teachers

Comentarios sobre reuniones de conexión en grupo

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7. Recomendaría estas reuniones de conexión en grupo a un amigo.	☐	☐	☐	☐	☒

Lo que más me gustó fue:
~~Todo~~ Las emosiones. Aprendí el quidado de niños.
Siempre hay cosas nuevas para aprecder
Soy más cosiente de lo que digo y hago con los niños.

Lo que me gustaría cambriar es:

Estaría muy interesado(a) en participar en reuniones de conexión en grupo sobre estos temas:

Over Phone

Parents as Teachers

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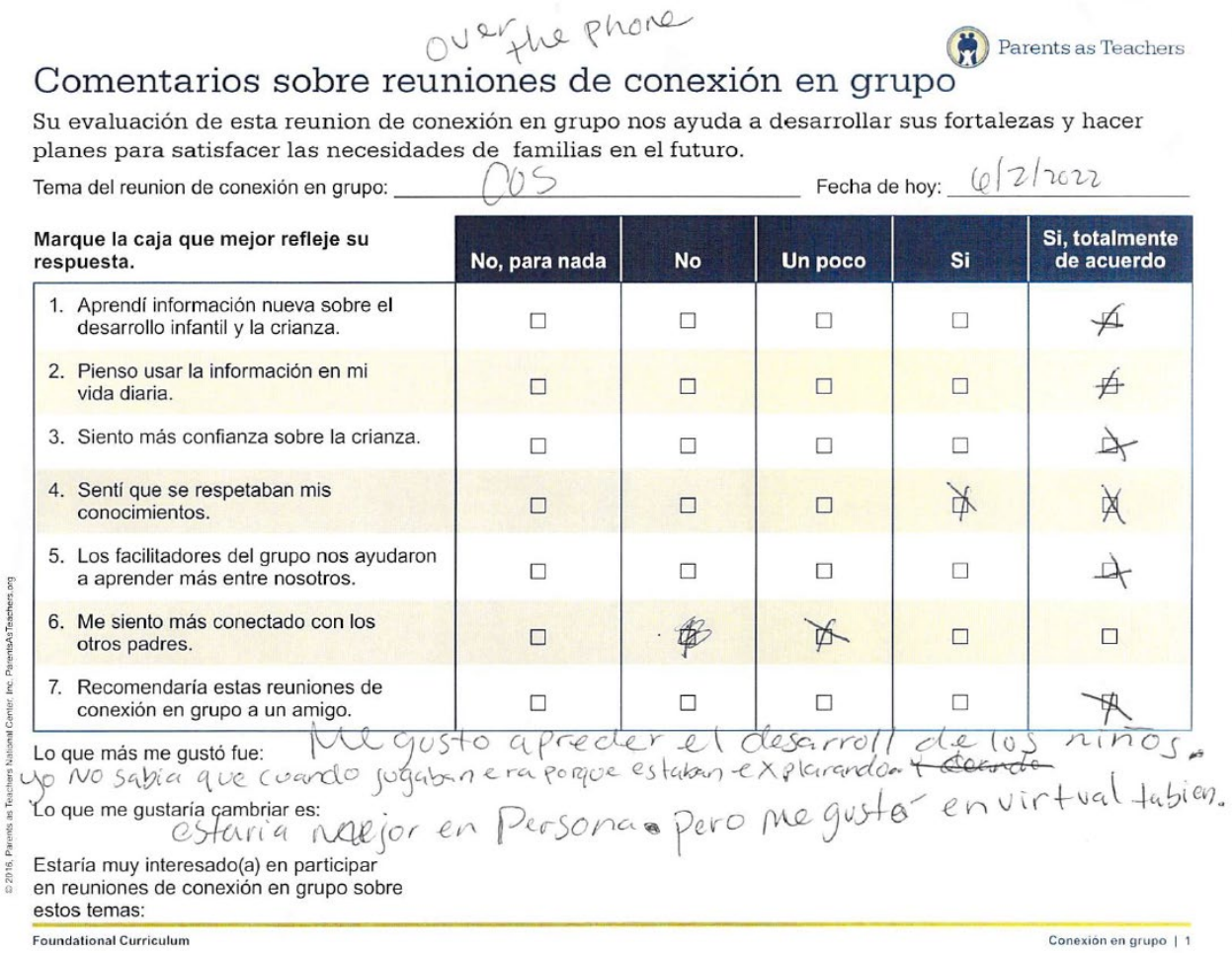
7. Recomendaría estas reuniones de conexión en grupo a un amigo.	☐	☐	☐	☐	☒

Lo que más me gustó fue: ~~Ciencia~~ De ser conectada/enclentificada con otros padres.

Lo que me gustaría cambriar es: Me gustaria que la clase fuera en persona.

Estaría muy interesado(a) en participar en reuniones de conexión en grupo sobre estos temas:



over the phone

Parents as Teachers

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4. Sentí que se respetaban mis conocimientos.	☐	☐	☐	☒	☒
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6. Me siento más conectado con los otros padres.	☐	☒	☒	☐	☐
7. Recomendaría estas reuniones de conexión en grupo a un amigo.	☐	☐	☐	☐	☒

Lo que más me gustó fue: Me gusto aprender el desarroll de los niños. yo No sabia que cuando jugaban era porque estaban explorando ~~y cuando~~

Lo que me gustaría cambriar es: estaria mejor en Persona. pero me gusta en virtual tabien.

Estaría muy interesado(a) en participar en reuniones de conexión en grupo sobre estos temas:

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Foundational Curriculum

Conexión en grupo | 1

Emeralda Owen/Public Service Announcements

Schedule of Public Service Announcements
June, 2021 (Brenda Almaraz)
Video 1: https://vimeo.com/554908227
-Theme: La Salud Mental (Mental Health General)

July, 2021 (Ruben Martin)
Video 2: https://vimeo.com/556338757
-Theme: Servicios para jóvenes y niños (Services for youth and children)

August, 2021 (Erandi García)
Video 3: https://vimeo.com/556374055
-Theme: El duelo (Grief/Hospice Giving Foundation)

September, 2021 (Isabel Bernal)
Video 7: https://vimeo.com/558232066
-Theme: Prevencion del suicidio (Suicide Prevention)

Monterey County Behavioral Health

Micro-Innovation Grant

PSA Project in Spanish by

Esmeralda Owen

2020 - 2021

October, 2021 (Fernanda Ocaña)
Video 4: https://vimeo.com/556396951
-Theme: La violencia domestica (Domestic Violence)

November, 2021 (Iván González)
Video 5: https://vimeo.com/556412487
-Theme: La depresion (Depression)

December, 2021 (Isabella Hernández)
Video 6: https://vimeo.com/556421462
-Theme: Los cuentos (Story-telling)

January, 2022 (Mónica Sánchez)
Video 9: https://vimeo.com/558292258
-Theme: La depresion post-parto (Post-partum depression)

February, 2022 (Arly Lara)
Video 8: https://vimeo.com/557824748
-Theme: Relaciones saludables (Healthy relationships)

March, 2022 (Maricarmen González)
Video 11: https://vimeo.com/558780718
-Theme: La salud de la mujer (Women's health)

April, 2022 (Dulce Silva)
Video 12: https://vimeo.com/559246650
-Theme: El abuso infantil (Child abuse)

May, 2022 (Ericel Jimenez)
Video 10: https://vimeo.com/558769676
-Theme: Mes de la salud mental (Mental Health Awareness Month)

Timeline

Monterey County Behavioral Health – PSA Project for Spanish Speaking and Indigenous Communities 2021-2022

TIMELINE OF WORK, TOPICS, AND DELIVERABLES by Esmeralda Owen April 5, 2021

MARCH/APRIL 2021	MAY	JUNE	JULY	AUGUST	SEPTEMBER	OCTOBER
-Grant Acceptance -Create timeline of deliverables -Purchase Liability Insurance Policy for $1,000,000.00 -Hire an intern-paid -Research topics to feature on PSAs -Identify talent for PSAs -Identify talent for Triqui and Mixteco -Write PSAs -Contract videographer-editing team -Identify members for an advisory group [Labor fees: $4,600]	-Scout video shoot locations -Schedule the video shoot days and coordinate talent *-Meet with advisory group for feedback on PSA copy* -Purchase gift cards as stipends for participants -Filming days: provide refreshments -Take photo stills of each participant for pictorials -Edit all PSAs for radio and TV with editor -Place the first ad [Labor fees: $2,300] [Video/Editing: $25,000 total – half due] [Invoice MCBH001 – $21,950.00]	-First ad placed on all media -Topic: General support for adults -Manage distribution -Report on number of ads aired -Manage analytics -Social media pictorials to share with partners and friends **-Radio 30-min show about campaign and other grantees** [Labor fees: $1,550] [Video/Editing: $12,500 due] [Invoice MCBH002 - $14,050.00]	-Place ad on all media -Topic: Services for children and youth -Manage distribution, numbers aired, and analytics -Social media pictorials *[Invoices will be $1,550 per month through March 2022]*	Place ad on all media -Topic: Grief counseling -Manage distribution, numbers aired, and analytics -Social media pictorials **-Radio 30-min show on La Buena**	Place ad on all media -Topic: Suicide Prevention -Manage distribution, numbers aired, and analytics -Social media pictorials	Place ad on all media -Topic: Domestic Violence *-Advisory Group meeting* -Manage distribution, numbers aired, and analytics -Social media pictorials *[NOTE: the management of the distribution, record keeping, analytics and post* *of pictorials will be monthly]*
NOVEMBER	DECEMBER	JANUARY 2022	FEBRUARY	MARCH	APRIL	MAY
-Place ads -Topic: Depression **-Radio 30-min show**	Place ads -Topic: Power of storytelling in kids	Place ad -Topic: Post-Partum depress. **-Radio 30-min show**	Place ad on all media -Topic: Healthy relationships	Place ad on all media -Topic: Women's health	Place ad on all media -Topic: Child Abuse **-Radio 30-min**	Place ad on all media -Topic: Mental health in general

Monthly Reports

June 2021 Report

ESMERALDA OWEN PR

MCBH PSA MONTHLY REPORT

JUNE '21

ESMERALDAMONTENEGROOWEN@GMAIL.COM

213.220.1174

1114 VALBUSA DR. GILROY, CA 95020

DANA EDGULL, LCSW
BEHAVIORAL HEALTH SERVICES MANAGER II
MONTEREY COUNTY BEHAVIORAL HEALTH

I hope this finds you well. This is my first official report on PSA Project distribution and other activities to disseminate information in Spanish in Monterey County about mental health services.

For June, we launched the campaign with BRENDA talking about mental health services in general. The link to his PSA is: La Salud Mental: https://vimeo.com/554908227

The PSA was delivered to these TV and Radio stations:

-La Buena/La Ranchera Radios
-La Preciosa Radio
-Radio Bilingüe
-Comcast Spotlight
-KION/Telemundo/CW
-KSBW/ABC/Estrella TV
-Univision, UniMas, TriColor

These TV and Radio stations confirmed receipt of the PSA and added it to their PSA rotation for the month. They have committed space for the remainder of the campaign! Yay!

In addition, on June 9, 2021, a 30-minute radio show was recorded to be aired via La Buena and La Ranchera. This show was about the PSA campaign in general.

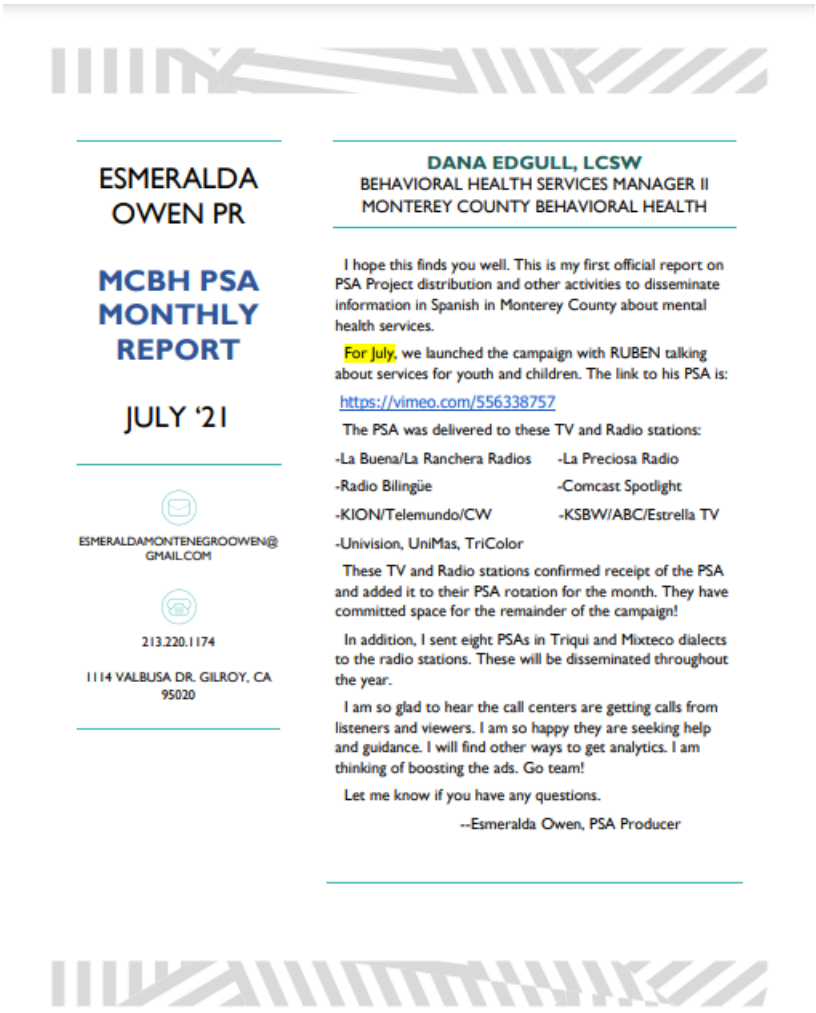
It is difficult to get analytics of TV and Radio spots, but I do know the Latino Community is listening.

The meeting we had in late June helped to finalize the 12 PSAs. I will be sending you all of those in the next days.

Let me know if you have any questions.

--Esmeralda Owen, PSA Producer

July 2021 Report



ESMERALDA OWEN PR

MCBH PSA MONTHLY REPORT

JULY '21

ESMERALDAMONTENEGROOWEN@GMAIL.COM

213.220.1174

1114 VALBUSA DR. GILROY, CA 95020

DANA EDGULL, LCSW
BEHAVIORAL HEALTH SERVICES MANAGER II
MONTEREY COUNTY BEHAVIORAL HEALTH

I hope this finds you well. This is my first official report on PSA Project distribution and other activities to disseminate information in Spanish in Monterey County about mental health services.

For July, we launched the campaign with RUBEN talking about services for youth and children. The link to his PSA is:

https://vimeo.com/556338757

The PSA was delivered to these TV and Radio stations:

-La Buena/La Ranchera Radios
-La Preciosa Radio
-Radio Bilingüe
-Comcast Spotlight
-KION/Telemundo/CW
-KSBW/ABC/Estrella TV
-Univision, UniMas, TriColor

These TV and Radio stations confirmed receipt of the PSA and added it to their PSA rotation for the month. They have committed space for the remainder of the campaign!

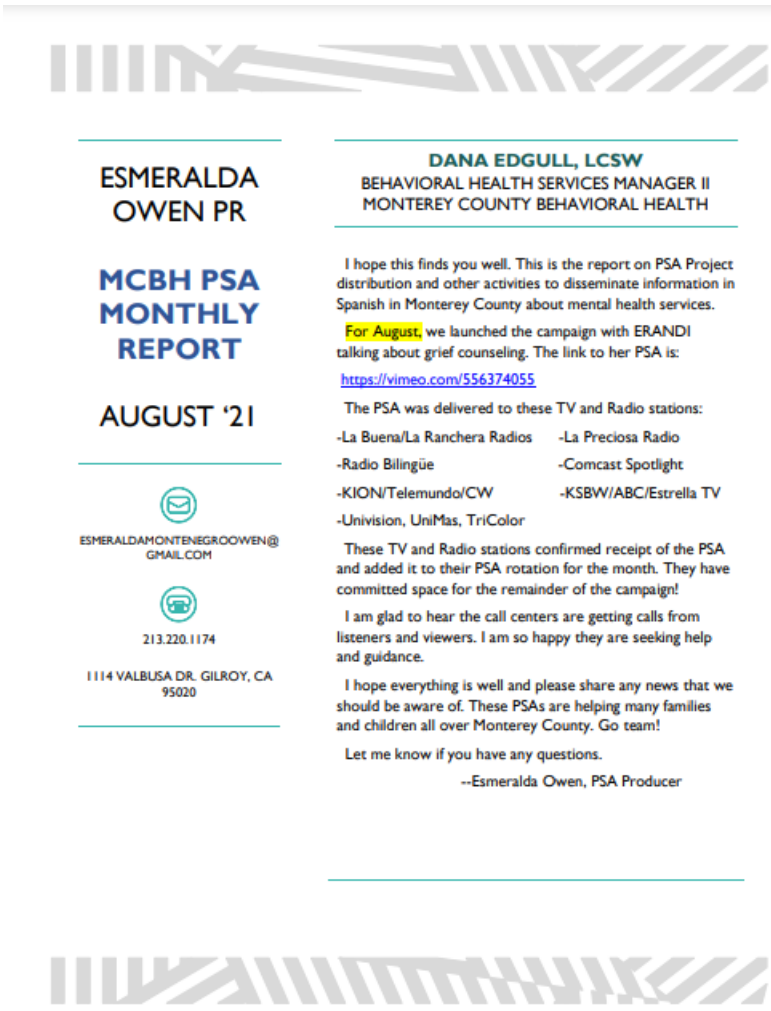
In addition, I sent eight PSAs in Triqui and Mixteco dialects to the radio stations. These will be disseminated throughout the year.

I am so glad to hear the call centers are getting calls from listeners and viewers. I am so happy they are seeking help and guidance. I will find other ways to get analytics. I am thinking of boosting the ads. Go team!

Let me know if you have any questions.

--Esmeralda Owen, PSA Producer

August 2021 Report



ESMERALDA OWEN PR

MCBH PSA MONTHLY REPORT

AUGUST '21

ESMERALDAMONTENEGROOWEN@GMAIL.COM

213.220.1174

1114 VALBUSA DR. GILROY, CA 95020

DANA EDGULL, LCSW
BEHAVIORAL HEALTH SERVICES MANAGER II
MONTEREY COUNTY BEHAVIORAL HEALTH

I hope this finds you well. This is the report on PSA Project distribution and other activities to disseminate information in Spanish in Monterey County about mental health services.

For August, we launched the campaign with ERANDI talking about grief counseling. The link to her PSA is:

https://vimeo.com/556374055

The PSA was delivered to these TV and Radio stations:

-La Buena/La Ranchera Radios
-La Preciosa Radio
-Radio Bilingüe
-Comcast Spotlight
-KION/Telemundo/CW
-KSBW/ABC/Estrella TV
-Univision, UniMas, TriColor

These TV and Radio stations confirmed receipt of the PSA and added it to their PSA rotation for the month. They have committed space for the remainder of the campaign!

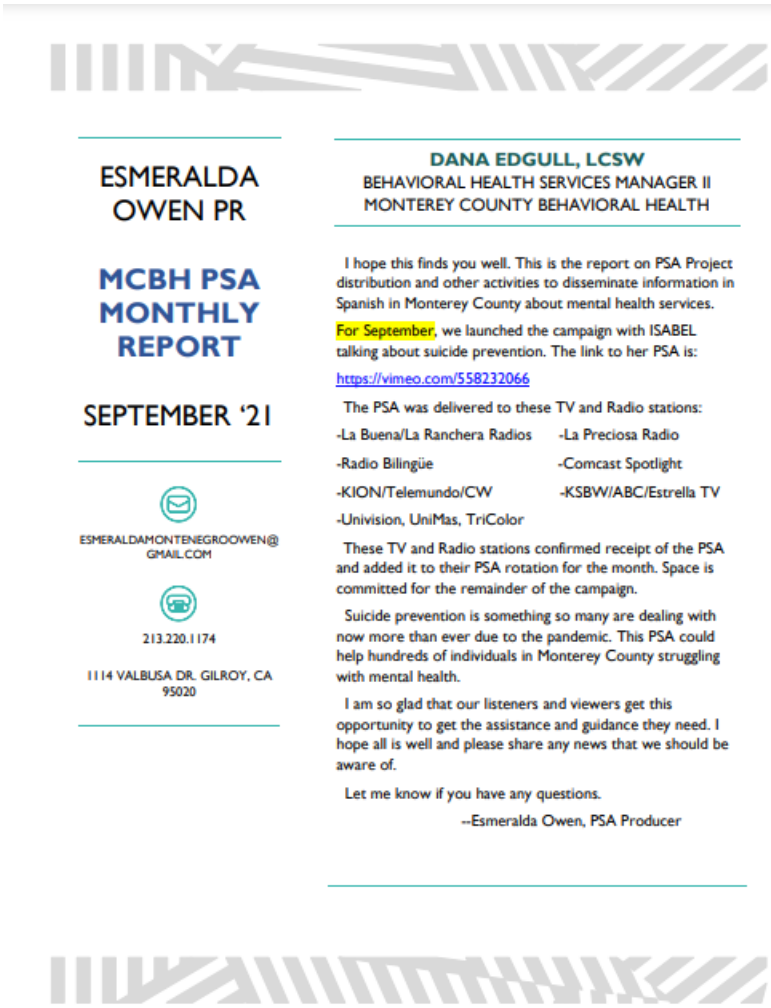
I am glad to hear the call centers are getting calls from listeners and viewers. I am so happy they are seeking help and guidance.

I hope everything is well and please share any news that we should be aware of. These PSAs are helping many families and children all over Monterey County. Go team!

Let me know if you have any questions.

--Esmeralda Owen, PSA Producer

September 2021 Report



ESMERALDA OWEN PR

MCBH PSA MONTHLY REPORT

SEPTEMBER '21

ESMERALDAMONTENEGROOWEN@GMAIL.COM

213.220.1174

1114 VALBUSA DR. GILROY, CA 95020

DANA EDGULL, LCSW
BEHAVIORAL HEALTH SERVICES MANAGER II
MONTEREY COUNTY BEHAVIORAL HEALTH

I hope this finds you well. This is the report on PSA Project distribution and other activities to disseminate information in Spanish in Monterey County about mental health services.

For September, we launched the campaign with ISABEL talking about suicide prevention. The link to her PSA is:

https://vimeo.com/558232066

The PSA was delivered to these TV and Radio stations:

-La Buena/La Ranchera Radios
-La Preciosa Radio
-Radio Bilingüe
-Comcast Spotlight
-KION/Telemundo/CW
-KSBW/ABC/Estrella TV
-Univision, UniMas, TriColor

These TV and Radio stations confirmed receipt of the PSA and added it to their PSA rotation for the month. Space is committed for the remainder of the campaign.

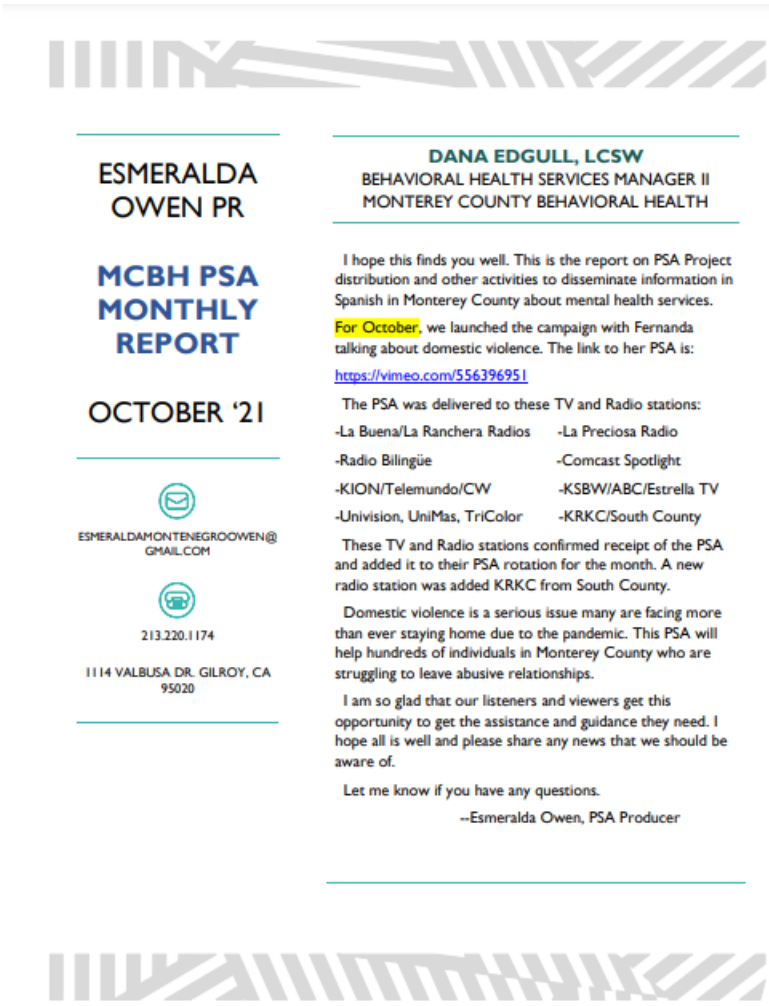
Suicide prevention is something so many are dealing with now more than ever due to the pandemic. This PSA could help hundreds of individuals in Monterey County struggling with mental health.

I am so glad that our listeners and viewers get this opportunity to get the assistance and guidance they need. I hope all is well and please share any news that we should be aware of.

Let me know if you have any questions.

--Esmeralda Owen, PSA Producer

October 2021 Report



ESMERALDA OWEN PR

MCBH PSA MONTHLY REPORT

OCTOBER '21

ESMERALDAMONTENEGROOWEN@GMAIL.COM

213.220.1174

1114 VALBUSA DR. GILROY, CA 95020

DANA EDGULL, LCSW
BEHAVIORAL HEALTH SERVICES MANAGER II
MONTEREY COUNTY BEHAVIORAL HEALTH

I hope this finds you well. This is the report on PSA Project distribution and other activities to disseminate information in Spanish in Monterey County about mental health services.

For October, we launched the campaign with Fernanda talking about domestic violence. The link to her PSA is:

https://vimeo.com/556396951

The PSA was delivered to these TV and Radio stations:

-La Buena/La Ranchera Radios
-La Preciosa Radio
-Radio Bilingüe
-Comcast Spotlight
-KION/Telemundo/CW
-KSBW/ABC/Estrella TV
-Univision, UniMas, TriColor
-KRKC/South County

These TV and Radio stations confirmed receipt of the PSA and added it to their PSA rotation for the month. A new radio station was added KRKC from South County.

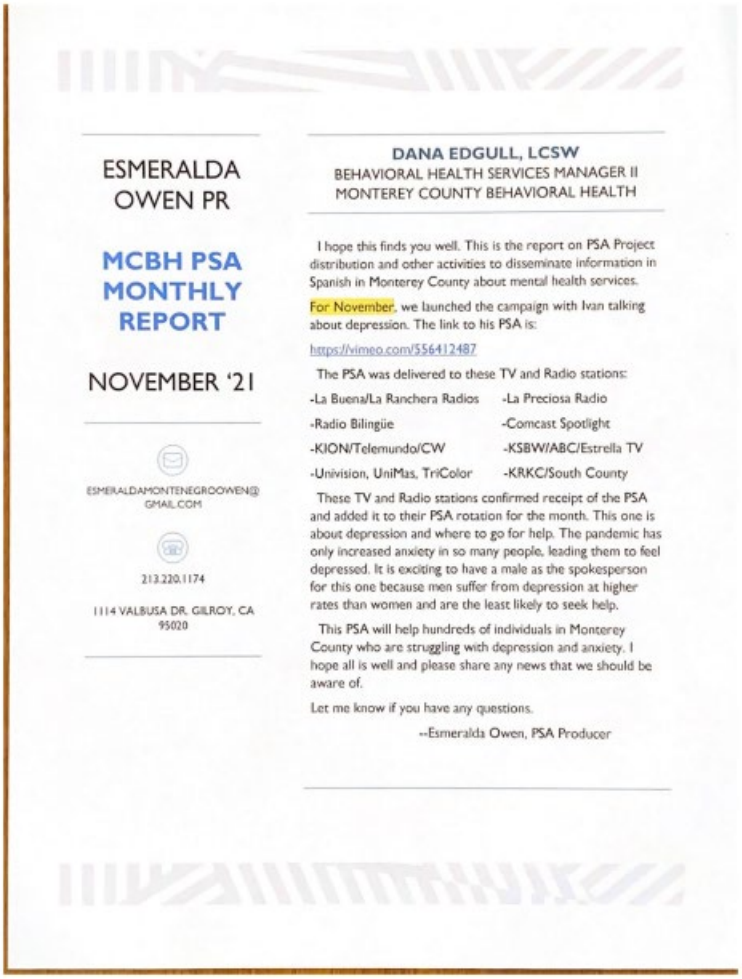
Domestic violence is a serious issue many are facing more than ever staying home due to the pandemic. This PSA will help hundreds of individuals in Monterey County who are struggling to leave abusive relationships.

I am so glad that our listeners and viewers get this opportunity to get the assistance and guidance they need. I hope all is well and please share any news that we should be aware of.

Let me know if you have any questions.

--Esmeralda Owen, PSA Producer

November 2021 Report



ESMERALDA OWEN PR

MCBH PSA MONTHLY REPORT

NOVEMBER '21

ESMERALDAMONTENEGROOWEN@GMAIL.COM

213.220.1174

1114 VALBUSA DR. GILROY, CA 95020

DANA EDGULL, LCSW
BEHAVIORAL HEALTH SERVICES MANAGER II
MONTEREY COUNTY BEHAVIORAL HEALTH

I hope this finds you well. This is the report on PSA Project distribution and other activities to disseminate information in Spanish in Monterey County about mental health services.

For November, we launched the campaign with Ivan talking about depression. The link to his PSA is:

https://vimeo.com/556412487

The PSA was delivered to these TV and Radio stations:

-La Buena/La Ranchera Radios
-La Preciosa Radio
-Radio Bilingüe
-Comcast Spotlight
-KION/Telemundo/CW
-KSBW/ABC/Estrella TV
-Univision, UniMas, TriColor
-KRKC/South County

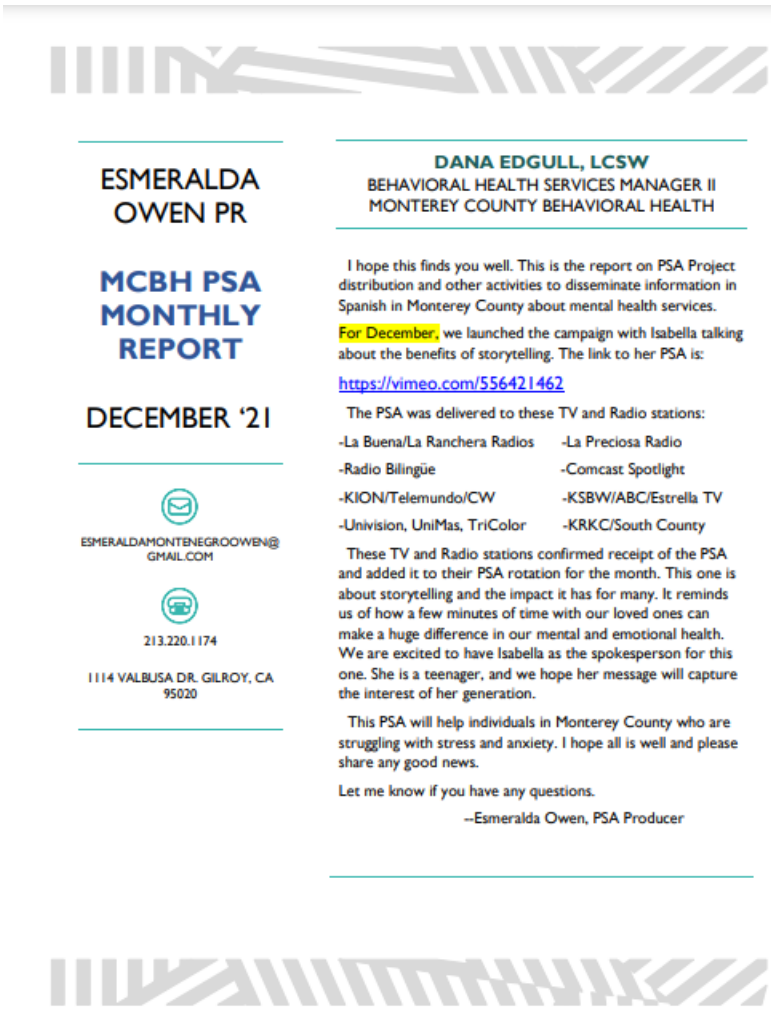
These TV and Radio stations confirmed receipt of the PSA and added it to their PSA rotation for the month. This one is about depression and where to go for help. The pandemic has only increased anxiety in so many people, leading them to feel depressed. It is exciting to have a male as the spokesperson for this one because men suffer from depression at higher rates than women and are the least likely to seek help.

This PSA will help hundreds of individuals in Monterey County who are struggling with depression and anxiety. I hope all is well and please share any news that we should be aware of.

Let me know if you have any questions.

--Esmeralda Owen, PSA Producer

December 2021 Report



ESMERALDA OWEN PR

MCBH PSA MONTHLY REPORT

DECEMBER '21

ESMERALDAMONTENEGROOWEN@GMAIL.COM

213.220.1174

1114 VALBUSA DR. GILROY, CA 95020

DANA EDGULL, LCSW
BEHAVIORAL HEALTH SERVICES MANAGER II
MONTEREY COUNTY BEHAVIORAL HEALTH

I hope this finds you well. This is the report on PSA Project distribution and other activities to disseminate information in Spanish in Monterey County about mental health services.

For December, we launched the campaign with Isabella talking about the benefits of storytelling. The link to her PSA is:

https://vimeo.com/556421462

The PSA was delivered to these TV and Radio stations:

-La Buena/La Ranchera Radios
-La Preciosa Radio
-Radio Bilingüe
-Comcast Spotlight
-KION/Telemundo/CW
-KSBW/ABC/Estrella TV
-Univision, UniMas, TriColor
-KRKC/South County

These TV and Radio stations confirmed receipt of the PSA and added it to their PSA rotation for the month. This one is about storytelling and the impact it has for many. It reminds us of how a few minutes of time with our loved ones can make a huge difference in our mental and emotional health. We are excited to have Isabella as the spokesperson for this one. She is a teenager, and we hope her message will capture the interest of her generation.

This PSA will help individuals in Monterey County who are struggling with stress and anxiety. I hope all is well and please share any good news.

Let me know if you have any questions.

--Esmeralda Owen, PSA Producer

January 2022 Report

ESMERALDA OWEN PR

MCBH PSA MONTHLY REPORT

JANUARY '22

ESMERALDAMONTENEGROOWEN@GMAIL.COM

213.220.1174

1114 VALBUSA DR. GILROY, CA 95020

DANA EDGULL, LCSW
BEHAVIORAL HEALTH SERVICES MANAGER II
MONTEREY COUNTY BEHAVIORAL HEALTH

I hope this finds you well. This is the report on PSA Project distribution and other activities to disseminate information in Spanish in Monterey County about mental health services.

For January, we launched the campaign with Monica talking about postpartum depression. The link to her PSA is: https://vimeo.com/558292258

The PSA was delivered to these TV and Radio stations:

-La Buena/La Ranchera Radios	-La Preciosa Radio
-Radio Bilingüe	-Comcast Spotlight
-KION/Telemundo/CW	-KSBW/ABC/Estrella TV
-Univision, UniMas, TriColor	-KRKC/South County

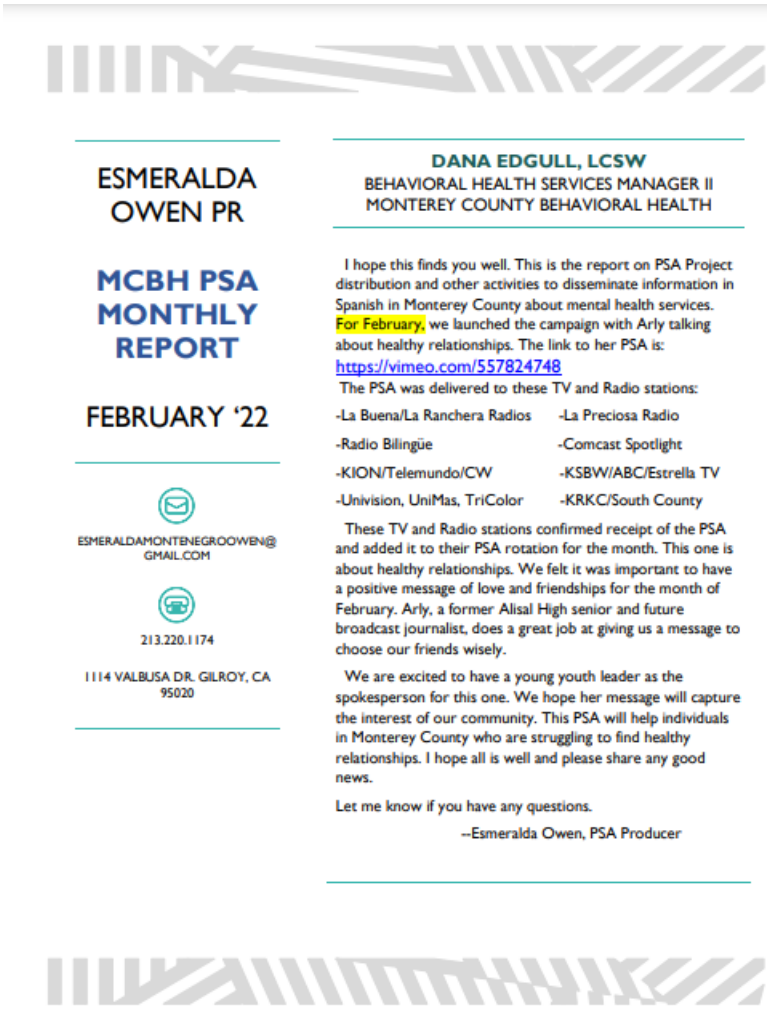
These TV and Radio stations confirmed receipt of the PSA and added it to their PSA rotation for the month. This one is about postpartum and the impact it has on women. It reminds us that it is normal to feel unwanted emotions for numerous first-time mothers and encourages women to seek help after giving birth. It will make a huge difference in their mental and emotional health. We are excited to have Monica as the spokesperson for this one. She is a mother, and we hope her message will capture the interest of our community.

This PSA will help individuals in Monterey County who are struggling with postpartum depression. I hope all is well and please share any good news.

Let me know if you have any questions.

--Esmeralda Owen, PSA Producer

February 2022 Report



ESMERALDA OWEN PR

MCBH PSA MONTHLY REPORT

FEBRUARY '22

ESMERALDAMONTENEGROOWEN@GMAIL.COM

213.220.1174

1114 VALBUSA DR. GILROY, CA 95020

DANA EDGULL, LCSW
BEHAVIORAL HEALTH SERVICES MANAGER II
MONTEREY COUNTY BEHAVIORAL HEALTH

I hope this finds you well. This is the report on PSA Project distribution and other activities to disseminate information in Spanish in Monterey County about mental health services. For February, we launched the campaign with Arly talking about healthy relationships. The link to her PSA is: https://vimeo.com/557824748

The PSA was delivered to these TV and Radio stations:

-La Buena/La Ranchera Radios
-La Preciosa Radio
-Radio Bilingüe
-Comcast Spotlight
-KION/Telemundo/CW
-KSBW/ABC/Estrella TV
-Univision, UniMas, TriColor
-KRKC/South County

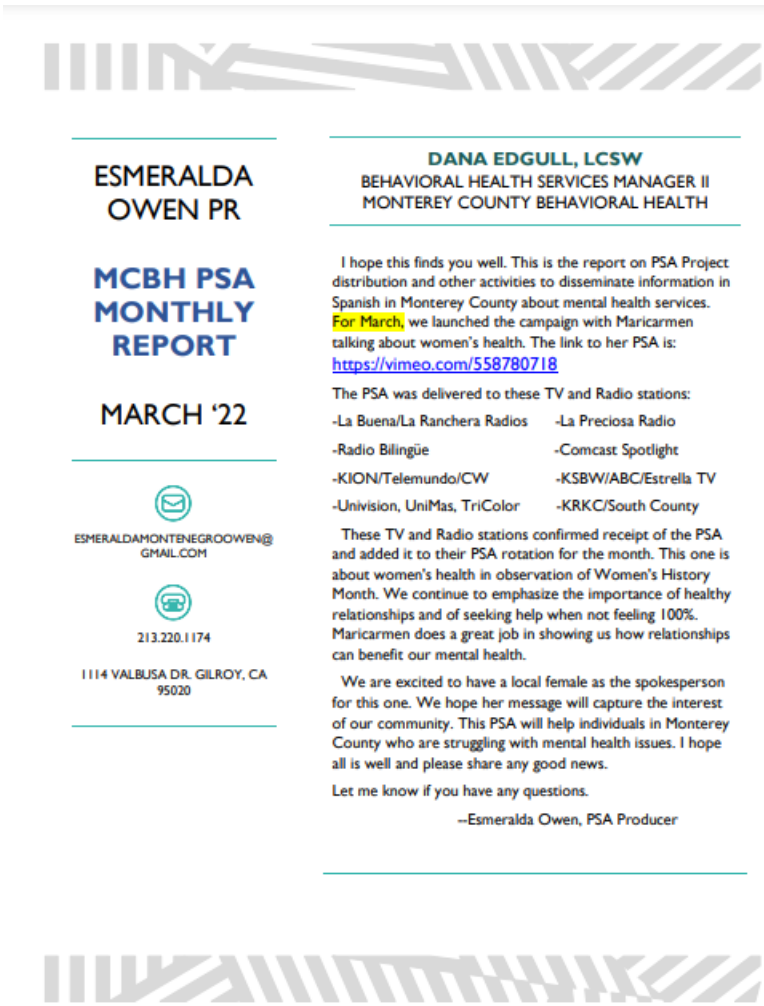
These TV and Radio stations confirmed receipt of the PSA and added it to their PSA rotation for the month. This one is about healthy relationships. We felt it was important to have a positive message of love and friendships for the month of February. Arly, a former Alisal High senior and future broadcast journalist, does a great job at giving us a message to choose our friends wisely.

We are excited to have a young youth leader as the spokesperson for this one. We hope her message will capture the interest of our community. This PSA will help individuals in Monterey County who are struggling to find healthy relationships. I hope all is well and please share any good news.

Let me know if you have any questions.

--Esmeralda Owen, PSA Producer

March 2022 Report



ESMERALDA OWEN PR

MCBH PSA MONTHLY REPORT

MARCH '22

ESMERALDAMONTENEGROOWEN@GMAIL.COM

213.220.1174

1114 VALBUSA DR. GILROY, CA 95020

DANA EDGULL, LCSW
BEHAVIORAL HEALTH SERVICES MANAGER II
MONTEREY COUNTY BEHAVIORAL HEALTH

I hope this finds you well. This is the report on PSA Project distribution and other activities to disseminate information in Spanish in Monterey County about mental health services. For March, we launched the campaign with Maricarmen talking about women's health. The link to her PSA is: https://vimeo.com/558780718

The PSA was delivered to these TV and Radio stations:

-La Buena/La Ranchera Radios
-La Preciosa Radio
-Radio Bilingüe
-Comcast Spotlight
-KION/Telemundo/CW
-KSBW/ABC/Estrella TV
-Univision, UniMas, TriColor
-KRKC/South County

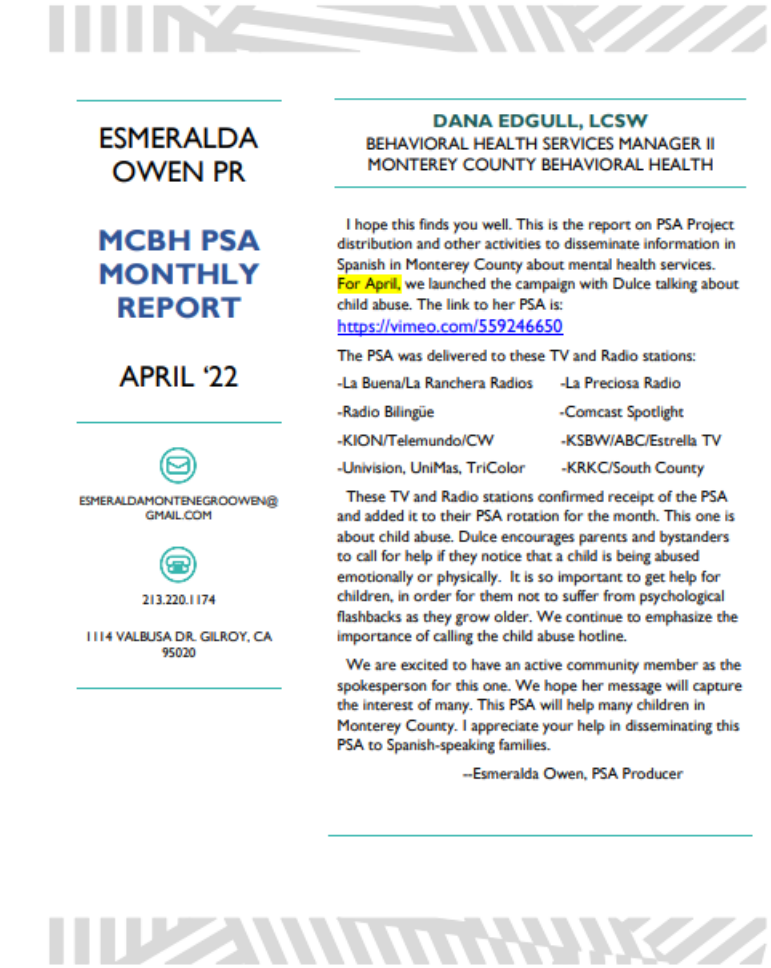
These TV and Radio stations confirmed receipt of the PSA and added it to their PSA rotation for the month. This one is about women's health in observation of Women's History Month. We continue to emphasize the importance of healthy relationships and of seeking help when not feeling 100%. Maricarmen does a great job in showing us how relationships can benefit our mental health.

We are excited to have a local female as the spokesperson for this one. We hope her message will capture the interest of our community. This PSA will help individuals in Monterey County who are struggling with mental health issues. I hope all is well and please share any good news.

Let me know if you have any questions.

--Esmeralda Owen, PSA Producer

April 2022 Report



ESMERALDA OWEN PR

MCBH PSA MONTHLY REPORT

APRIL '22

ESMERALDAMONTENEGROOWEN@GMAIL.COM

213.220.1174

1114 VALBUSA DR. GILROY, CA 95020

DANA EDGULL, LCSW
BEHAVIORAL HEALTH SERVICES MANAGER II
MONTEREY COUNTY BEHAVIORAL HEALTH

I hope this finds you well. This is the report on PSA Project distribution and other activities to disseminate information in Spanish in Monterey County about mental health services. For April, we launched the campaign with Dulce talking about child abuse. The link to her PSA is:
https://vimeo.com/559246650

The PSA was delivered to these TV and Radio stations:

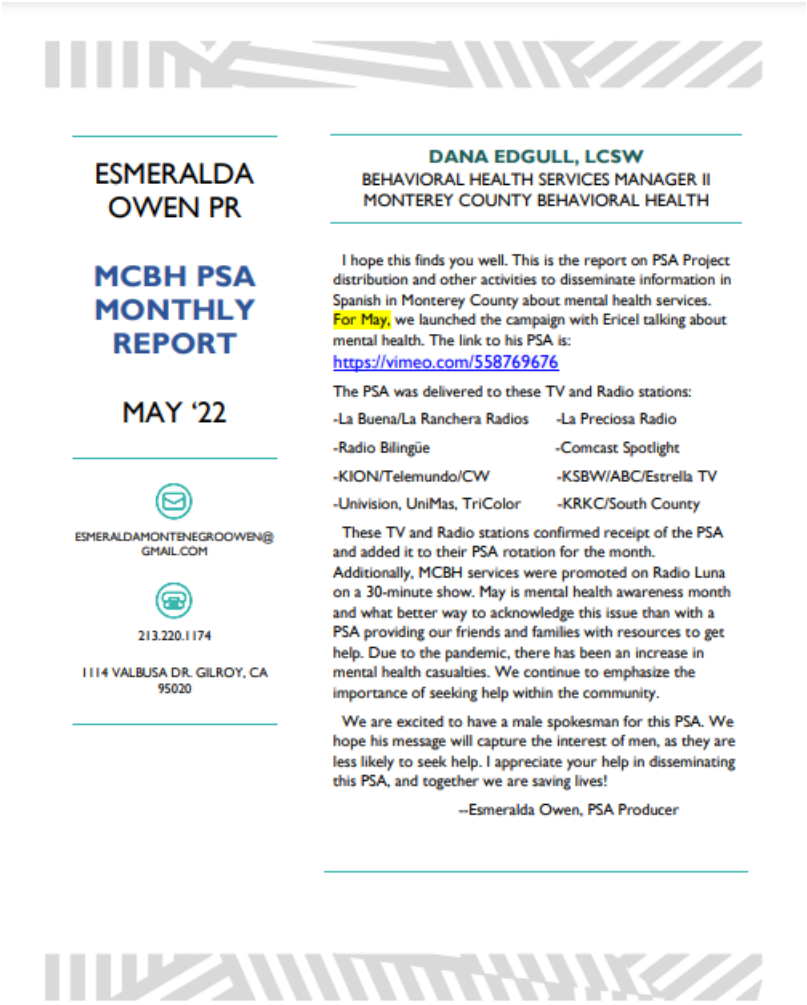
-La Buena/La Ranchera Radios	-La Preciosa Radio
-Radio Bilingüe	-Comcast Spotlight
-KION/Telemundo/CW	-KSBW/ABC/Estrella TV
-Univision, UniMas, TriColor	-KRKC/South County

These TV and Radio stations confirmed receipt of the PSA and added it to their PSA rotation for the month. This one is about child abuse. Dulce encourages parents and bystanders to call for help if they notice that a child is being abused emotionally or physically. It is so important to get help for children, in order for them not to suffer from psychological flashbacks as they grow older. We continue to emphasize the importance of calling the child abuse hotline.

We are excited to have an active community member as the spokesperson for this one. We hope her message will capture the interest of many. This PSA will help many children in Monterey County. I appreciate your help in disseminating this PSA to Spanish-speaking families.

--Esmeralda Owen, PSA Producer

May 2022 Report



ESMERALDA OWEN PR

MCBH PSA MONTHLY REPORT

MAY '22

ESMERALDAMONTENEGROOWEN@GMAIL.COM

213.220.1174

1114 VALBUSA DR. GILROY, CA 95020

DANA EDGULL, LCSW
BEHAVIORAL HEALTH SERVICES MANAGER II
MONTEREY COUNTY BEHAVIORAL HEALTH

I hope this finds you well. This is the report on PSA Project distribution and other activities to disseminate information in Spanish in Monterey County about mental health services. For May, we launched the campaign with Ericel talking about mental health. The link to his PSA is:
https://vimeo.com/558769676

The PSA was delivered to these TV and Radio stations:

-La Buena/La Ranchera Radios
-La Preciosa Radio
-Radio Bilingüe
-Comcast Spotlight
-KION/Telemundo/CW
-KSBW/ABC/Estrella TV
-Univision, UniMas, TriColor
-KRKC/South County

These TV and Radio stations confirmed receipt of the PSA and added it to their PSA rotation for the month. Additionally, MCBH services were promoted on Radio Luna on a 30-minute show. May is mental health awareness month and what better way to acknowledge this issue than with a PSA providing our friends and families with resources to get help. Due to the pandemic, there has been an increase in mental health casualties. We continue to emphasize the importance of seeking help within the community.

We are excited to have a male spokesman for this PSA. We hope his message will capture the interest of men, as they are less likely to seek help. I appreciate your help in disseminating this PSA, and together we are saving lives!

--Esmeralda Owen, PSA Producer

Round 5

Monterey County Public Health Bureau

"POSTPONE PROGRAM ADAPTATION"

FOR INCLUSION OF
BEHAVIORAL HEALTH SERVICES EDUCATION AND REFERRAL SERVICES

August 1, 2021 to June 30, 2022


MONTEREY COUNTY CALIFORNIA
1850

Contents

Project Summary

Monterey County Health Department's Postpone Program served schools in the Salinas Union High School District (SUHSD) and North Monterey County Middle School by providing training, education, and resources in the areas of mental health and teen pregnancy prevention services. This micro innovation project was completed through Postpone (a teen pregnancy prevention program) that has been implemented in our community for over 25 years. All incoming freshmen at Alisal High School, and students taking health education at Everett Alvarez High School, were served by way of peer education and fotonovela (a storytelling tool to engage youth in learning about issues such as health and other adult preparation topics).

This micro innovation project was proposed to bridge an information gap. Prior to the micro innovation project youth received information and education related to their physical development, sexual and reproductive health, and other adult preparation areas. However, Postpone had not addressed youth mental health needs or provided mental health resources. Postpone facilitators had noted that trauma, depression, and anxiety seemed to be among the mental health issues commonly observed in program participants and these were occasionally disclosed to the facilitators by the students themselves.

Postpone staff proposed to expand the program to address youth mental health needs by providing mental health education directly to youth and by making and tracking referrals to Behavioral Health. The goal was to train a minimum total of 30 high school students at Alisal and Everett Alvarez High Schools and one college level student intern to serve as peer educators through implementation of the Mind Matters curriculum. A second goal was to reach a total of 1,030 students from Alisal and Everett Alvarez through classroom presentations. Postpone peer educators completed one-on-one outreach to their peers, documented their interactions, and posted to their personal social media accounts including Instagram and Snapchat positive messages about accessing mental health services, tips on mental health, and mental health resources. Posts were intended to reduce stigma and increase the understanding of mental health resources and services.

In the city of Salinas, where both Alisal and Everett Alvarez High Schools are located, a Latinx family is three times more likely to live below the poverty level compared to a White, non-Hispanic family (2019 ACS, 1-Year Estimates US Census Bureau). The Centers for Disease Control and Prevention noted in a 2016 report (Vaughn, M.G., Salas-Wright, C.P. & Maynard, B.R. J Public Health (2014) 22: 265) that one important strategy to prevent and reduce health disparities is increased education in general, including high school completion. This proposal aligned with this strategy to support reducing health disparities and addressed some of the barriers to high school completion, such as teen pregnancy and unmet mental health needs. This project was built on the success of the Postpone program in reaching and engaging youth to provide outreach, information, and referrals for youth.

Many young people who need mental health treatment do not receive it. Research suggests that adolescents are more likely to modify their behaviors and attitudes if they receive health messages from peers who face similar concerns and pressures, Fatemeh Abdi, (2013) The Peer Education Approach in Adolescents. Teens often go to other teens to get help for things such as reproductive health, homework, employment, etc. The Postpone program used a peer education

model and students received accurate information and resources from their peers. Postpone peer educators were assigned to classrooms to speak on topics such as depression, anxiety, and mental health to normalize discussing mental health services and to increase the likelihood that the youth in the classrooms will seek mental health services.

The Postpone program purchased from The Dibble Institute the evidence-based Mind Matters curriculum and training. Mind Matters was implemented to help youth overcome adversity and build resilience. Mind Matters has been used by other agencies to prevent violence, address chronic absenteeism, and build a culture of wellness. Mind Matters lessons addressed the following topics:

- Self-Soothing and Regulating Emotions: Cultivating a mindfulness practice
- Managing Stress Effectively: Learning to reduce intrusive thoughts
- Developing Empathy: Improving interpersonal communications
- Creating a Code of Honor: Developing a life of intention
- Building and Using a Support System: Learning how to ask for help

Postpone peer educators and college interns were trained in the Mind Matters curriculum. Through peer educator presentations and other interactions high school students were given tools to seek help and address some of the mental health issues they might be experiencing. Postpone peer educators and a student intern, under the guidance of a public health coordinator, were a natural fit to learn this curriculum and apply the learned skills to their outreach and presentations. The skills taught in Mind Matters were designed to be practiced over a lifetime. The curriculum did not replace therapy.

Peer Educators

Postpone trained and recruited high school students in Salinas from both Alisal and Everett Alvarez High Schools, ages 13-18, to be part of the peer education program. Peer educators learned the standard Postpone topics in adult preparation, sexual and reproductive health, and additionally through this project they learned to promote mental health and access to services. The initial goal was to train a minimum of 15 Postpone peer educators at each of the high schools (a minimum total of 30 peer educators). Postpone exceeded this goal.

During the 2021-2022 school year Postpone trained 65 peer educators. 59 peer educators were from Alisal High School and 6 were from Everett Alvarez High School. The Alisal High School site had the benefit of a very involved teacher as the Postpone advisor. Additional activities and incentives were possible with the involvement of a supportive teacher. While Everett Alvarez High School also designated a teacher, the assigned teacher had limited availability to dedicate to the project.

Every effort was made for peer educators to complete 100% of the training and when completion was not possible, due to unplanned circumstances, the peer educators were required to complete at least 75% of the training to continue as peer educators. 59 peer educators completed 100% of the peer educator training and only 6 students completed less than 75% of the training.

Most schools served were in the Salinas Union High School District (SUHSD). SUHSD consists of five high schools, four middle schools, one independent study school, one alternative high school, Regional Occupational Program Center, and an Adult School. In 2021-2022 district enrollment was 16,525 students with 84% unduplicated count of the students qualifying for Free and Reduced Lunch, English Learners, and Foster Youth. Schools within the SUHSD have interventions during the school day, inter-sessions, and on Saturdays to provide support to students as needed.

Peer Educator Engagements with Students

The schools' students were the proposed focus population and included a significant number of students who are facing language barriers in accessing County services. According to Ed-data.org in 2021-2022, approximately 21% of students at Alisal High School and 18% at Everett Alvarez, were English learners. Both schools serve speakers of languages beyond Spanish, such as Tagalog, Korean, and many indigenous languages including Triqui, Mixtec, Zapotec, and Nahuatl.

<u>2021-2022 student enrollment in the schools served:</u>

- Alisal High School 3,008 students
    - Total minority enrollment is 99%
    - 94% of students are economically disadvantaged
- Everett Alvarez High School 2,113 students
    - Total minority enrollment is 97%
    - 89% of students are economically disadvantaged

- North Monterey County Middle School 679 students
    - Total minority enrollment is 93%
    - 83% of students are economically disadvantaged.
- Rancho San Juan High School 1,249 students
    - Total minority enrollment is 93%
    - 84% of students are economically disadvantaged

Upon completion of the Mind Matters curriculum, peer educators adapted program material to include behavioral health information to fellow students via in person presentations and other in person contacts as well as through their personal social media accounts. Peer educators also made themselves available to students one on one. In addition to adding information on mental health services to their presentations, the Postpone program included information on flyers and posted information in the classrooms. All students who are present during peer educator presentations received a resource sheet of existing mental health services available in our county. Each student that attended the Postpone presentations received information about how to make clinical mental health appointments. Under the direction of the Health Program Coordinator, the program interns made weekly calls to students to see if the students attended at least one of their Behavioral Health appointments.

Peer educators presented and promoted program material to students which included behavioral health messages and resources to all freshmen at Alisal High School during the Advancement Via Individual Determination (AVID) program. The AVID program is a nationally recognized program that prepares students for four-year college eligibility. Peer educators also presented at

health classes at Everett Alvarez High School. When presenting at Everett Alvarez High School was not possible due to the school's limited staff resources, presentations were completed at North Monterey County Middle School and at Rancho San Juan High School.

Each peer educator completed at least one social media post. During the project term at least 65 posts were created. Posts were made by peer educators directly to their personal social media accounts including Instagram and Snapchat. Posts included positive messages about accessing mental health services, tips on mental health, and mental health resources. Posts were intended to reduce stigma and increase the understanding of mental health resources and services. Social media analytics such as "likes, comments, share and saves" were not possible to track during the project due to students posting on their own social media platforms as stories rather than as reels on the Postpone program account.

While stories and snapchats remained for short periods of time and then were automatically deleted, the advantage to posting information in this manner was that the stories and snapchats were seen by more youth than if the post had been limited to those following the program feed as originally planned. Upon further assessment of the program account followers, it was determined the followers to this account would not meet the project goals and the decision was made to encourage youth to post on personal accounts. Based on empirical data from our student interns and peer educators, content associated with high-engagement social media posts were those posts which provided an interactive yet somewhat "anonymous" way to ask questions and share experiences and posts which reassured youth that they are not alone in feeling depressed, anxious, stressed, etc.

The initial goal was for peer educators to reach an unduplicated 1,030 youth through Postpone. Through classroom presentations alone this goal was exceeded. 77 presentations were completed and through these presentations peer educators reached 1,740 unduplicated youth through Postpone. Another 1,000 youth were reached through Making Proud Choices (MPC). MPC is another teen pregnancy program offered by Public Health. Had social media analytics been available, the reported number of students reached would have been even higher.

Behavioral Health Service Referrals

The goal was to refer into services 10% of youth reached (103 youth based on the original goal). Tracking the number of youths referred into services was challenging and Postpone was unable to accurately track this number. Among the challenges experienced were requests from students declining to state either verbally or through survey whether they had called the Behavioral Health telephone number (888-258-6029), spoken to Behavioral Health staff, or attended an appointment. Students stated they preferred to keep this confidential, including keeping this confidential from their peer educators. Peer educators reported another challenge, several students indicated they were more comfortable seeking services at the school (e.g., school wellness center) rather than calling a Behavioral Health clinic because they didn't know who would be on the other end of the telephone line and feared they would be judged. A third challenge in tracking was the Postpone program's unexpected change in staff, including retirement of the Project Director. Reduced staffing impacted the program's ability to further troubleshoot tracking of referrals.

Each student was assigned a unique participant number. Program staff had initially planned that these numbers could assist in tracking and reporting out how many youths had been referred, sought, and received services. However, without the students' willingness to disclose to Behavioral Health their unique participant number, that they were being referred by Postpone Peer Educators, reporting to peer educators that they called the intake number, or visited the wellness center, a direct correlation to our outreach efforts was not possible.

Postpone program is open to troubleshooting solutions for tracking should a future project be proposed. At this time, Postpone is only able to accurately track only the number of youths reached through presentations. 1,740 youth participating in presentations were provided with information on accessing Behavioral Health Services.

Peer educators assisted the Chronic Disease Prevention Coordinator with follow ups. Follow ups were completed in group and/or one-on-one. During the follow ups completed by peer educators, the peer educators had 20 students voluntarily disclose that they sought mental health services at school or following a Postpone presentation. It is unknown how many of the 20 students sought services at school and how many sought services through Behavioral Health, this information was not disclosed to peer educators.

Description Of Successes, Challenges And Barriers

Successes associated with this project included initiating conversations and sharing information with youth about mental health and seeking mental health services. Postpone provided a safe space for youth to hear about and normalize the topic of mental health. Some youth shared their own experiences, and this reminded other students that mental health issues are common, and that support is available.

Peer Educators stated they really liked the Mind Matters content. The information they learned was shared with others via social media posts, and during one-on-one conversations with students. Peer educators also reported that they were using the information learned to help their siblings and friends. Peer educators learned to identify some of the signs, such as declines in school performance, poor grades, constant anxiety, social withdrawal, or aggression, which may indicate the need for mental health services. The Mind Matters curriculum assisted not just our Postpone peer educators but also facilitators and students across all our teen pregnancy prevention programs to clear away barriers to their own focus and learning and helped to build skills in the educators that transferred to others through one-on-one interactions.

If this program were regularly offered through Postpone it could contribute towards improved perceptions of mental health services and promote greater help-seeking behavior among our youth. If the program were to be offered again, challenges and barriers associated with this project must be addressed. These include developing a tracking system for: the number of youths referred, number of youths who called Behavioral Health, number of youths who sought services through other resources such as school counselors or wellness centers, and calls which were a direct result of information shared through Postpone peer educators.

Youth requested that future projects have an anonymous way to track referrals because seeking mental health services is not something they want to openly share. Youth stated they feared stigma with accessing mental health services and stated they felt embarrassed or ashamed. Youth

were unwilling to share whether they had called Behavioral Health or accessed services. Postpone Peer Educators encountered a resistance from students in sharing this information in groups and individually through follow ups.

During follow ups and debriefs some youth reported hearing from other youth of "bad service" when calling the Behavioral Health referral number. No additional detail was provided on this. Due to the context of the discussion, the program believes this information could have stemmed from the students' being asked for identifying information by the person answering the Behavioral Health phone. In other words, students may have felt discouraged to seek help by having to provide their identifying information. Other students reported that they received the help they needed when calling the Behavioral Health number, yet it was unclear when they had called and if services were sought during the project timeline.

Students reported being confused about the referral and intake process, not understanding whether they should call back or if someone was going to call them back. Some students who shared information with peer educators stated intake forms were challenging to complete. Lastly, youth reported concerns with some school procedures requiring students to first obtain a referral from their school's academic counselor prior to seeking mental health services through the school's wellness center.

Recommendations

Anonymity and confidentiality around referrals and appointments was critically important to the youth in this project. Youth did not wish to share, even with the peer educators who they had built relationships with, any information about accessing Behavioral Health services. Students recommended implementation of services which would allow youth to access care and support anonymously if possible. Postpone staff found that students were concerned about the confidentiality of their information/record. Similar to the concerns students have when staff make referrals to Family Pact clinics for medical appointments. Students are concerned about who will have access to their record, specifically if a parent will be able to access their record. More education and information services are needed by students on the right to privacy when seeking Behavioral Health services.

From this project Postpone staff learned that to become more responsive for this population there must be a more instant way to refer students directly to an on-call professional. Youth recommended a referral number that is dedicated to teens and can be accessed via text (the benefit they reported would be receiving immediate support and "wouldn't be as scary as calling and talking to someone"). While crisis text lines are available to youth through national and state resources, staff and peer educators were unaware of local text options for youth who are seeking ongoing mental health support in a non-crisis situation. A local text option for teens is highly recommended.

Lastly, students shared concerns and confusion over school procedures/policies regarding how to access Behavioral Health or counseling services. Students shared that different schools seem to have different procedures. Students expressed concern over "extra and unnecessary hurdles" such as at one school a requirement to see their school counselor before being "allowed" to go to the wellness clinic or other mental health support person. Increased information to students and schools is recommended on the role of a school guidance counselor in the high schools and their

role in making referrals to Behavioral Health.

Acknowledgement

Postpone gratefully acknowledges Monterey County Behavioral Health Micro Innovation Grant 2021-2022 for funding adaptations to the Postpone Program to support local students in learning about and accessing behavioral health services.

Students reached at Alisal High School 2021-2022

Alisal High School																											
	AHS_10/27/2021_PatelPer1	AHS_10/27/2021_PatelPer2	AHS_10/27/2021_PatelPer3	AHS_10/27/2021_PatelPer4	AHS_10/27/2021_PatelPer5	AHS_10/27/2021_PatelPer6	AHS_03/23/22_MadrigalPer1	AHS_03/23/22_MadrigalPer2	AHS_03/23/22_MadrigalPer3	AHS_03/23/22_MadrigalPer4	AHS_03/23/22_MadrigalPer5	AHS_03/23/22_MadrigalPer6	AHS_03/25/22_BundenPer1	AHS_03/25/22_BundenPer2	AHS_03/25/22_BundenPer3	AHS_03/25/22_BundenPer5	AHS_03/25/22_BundenPer6	AHS_03/23/22_GrantPer2	AHS_03/23/22_GrantPer3	AHS_03/23/22_GrantPer4	AHS_03/23/22_GrantPer5	AHS_03/23/22_GrantPer6					Total Percentage
Gender																											
Female	17	10	12	15	17	10	11	11	18	16	12	15	21	15	11	13	9	13	11	8	10	16				291	50%
Male	10	12	16	13	12	19	11	17	12	12	11	12	8	12	16	12	14	11	18	17	15	9				289	50%
NA	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0				0	0%
Gender Total	27	22	28	28	29	29	22	28	30	28	23	27	29	27	27	25	23	24	29	25	25	25	0	0	0	580	100%
Age																											
11	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0				0	0%
12	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0				0	0%
13	1	1	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0				4	1%
14	25	19	26	25	27	27	12	23	21	15	12	17	16	12	18	12	13	12	15	13	19	14				393	68%
15	1	2	2	1	2	2	10	5	9	13	11	10	13	15	9	13	10	12	14	12	6	11				183	32%
16	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0				0	0%
17	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0				0	0%
18	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0				0	0%
19	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0				0	0%
NA	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0				0	0%
Age Total	27	22	28	28	29	29	22	28	30	28	23	27	29	27	27	25	23	24	29	25	25	25	0	0	0	580	100%
Ethnicity																											
Latino	25	21	28	28	27	27	22	25	28	28	23	27	28	27	27	25	21	23	29	25	25	25				564	97%
White	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	0	0	0	0				2	0%
African	0	0	0	0	0	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0				2	0%
Amer Indian	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0				0	0%
Pacific Islander	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0				1	0%
Asian	2	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0				5	1%
Other	0	1	0	0	0	2	0	2	0	0	0	0	1	0	0	0	0	0	0	0	0	0				6	1%
Blank	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0				0	0%
Ethnicity Total	27	22	28	28	29	29	22	28	30	28	23	27	29	27	27	25	23	24	29	25	25	25	0	0	0	580	100%

22 presentations, 580 students

Alisal High School																																								
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36		
	AHS_04/05/2022_PatelPer1	AHS_04/05/2022_PatelPer2	AHS_04/05/2022_PatelPer3	AHS_04/05/2022_PatelPer4	AHS_04/05/2022_PatelPer5	AHS_04/05/2022_PatelPer6	AHS_04/07/22_BundenPer1	AHS_04/07/22_BundenPer2	AHS_04/07/22_BundenPer3	AHS_04/07/22_BundenPer5	AHS_04/07/22_BundenPer6	AHS_04/26/22_GrantPer2	AHS_04/26/22_GrantPer3	AHS_04/26/22_GrantPer4	AHS_04/26/22_GrantPer5	AHS_04/26/22_GrantPer6	AHS_04/27/22_MadrigalPer1	AHS_04/27/22_MadrigalPer2	AHS_04/27/22_MadrigalPer3	AHS_04/27/22_MadrigalPer4	AHS_04/27/22_MadrigalPer5	AHS_04/27/22_MadrigalPer6																	Total Percentage
Gender																																								
Female	18	11	11	16	17	10	23	18	12	13	11	11	10	6	11	9	14	10	18	16	14	15															294	
Male	14	12	15	12	11	17	8	13	18	12	14	13	18	15	12	10	9	16	9	11	10	12															281	49%
NA	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0															0	0%
Gender Total	32	23	26	28	28	27	31	31	30	25	25	24	28	21	23	19	23	26	27	27	24	27	0	0	0	0	0	0	0	0	0	0	0	0	0	0	575	49%
Age																																								
11	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0															0	0%
12	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0															0	0%
13	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0															0	0%
14	20	13	11	16	18	15	17	14	17	11	12	10	13	9	15	7	9	18	13	13	12	16															299	52%
15	12	10	15	12	10	12	14	17	13	14	13	14	15	12	8	12	14	8	14	14	12	11															276	48%
16	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0															0	0%
17	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0															0	0%
18	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0															0	0%
19	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0															0	0%
NA	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0															0	0%
Age Total	32	23	26	28	28	27	31	31	30	25	25	24	28	21	23	19	23	26	27	27	24	27	0	0	0	0	0	0	0	0	0	0	0	0	0	0	575	100%
Ethnicity																																								
African A	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0															1	0%
Latino/His	31	23	26	28	25	25	31	30	30	25	20	23	28	21	23	19	23	25	23	27	23	27															556	97%
White	0	0	0	0	0	0	0	0	0	0	5	0	0	0	0	0	0	0	2	0	0	0															7	1%
American I	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0															0	0%
Pacific Is	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0															1	0%
Asian	1	0	0	0	2	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0															4	1%
Other	0	0	0	0	1	2	0	0	0	0	0	1	0	0	0	0	0	1	0	0	1	0															6	1%
NA	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0															0	0%
Ethnicity Total	32	23	26	28	28	27	31	31	30	25	25	24	28	21	23	19	23	26	27	27	24	27	0	0	0	0	0	0	0	0	0	0	0	0	0	0	575	100%

22 presentations, 575 students

Students reached at North Monterey County Middle School and Rancho San Juan 2022

North Monterey County Middle School and Rancho San Juan																								
NMCMS_03/09/2022_SantanaPer1	NMCMS_03/09/2022_SantanaPer2	NMCMS_03/09/2022_SantanaPer4	NMCMS_03/09/2022_SantanaPer6	NMCMS_03/16/2022_SantanaPer1	NMCMS_03/16/2022_SantanaPer2	NMCMS_03/16/2022_SantanaPer4	NMCMS_03/16/2022_SantanaPer6	NMCMS_05/18/2022_SantanaPer2	NMCMS_05/18/2022_SantanaPer3	NMCMS_05/18/2022_SantanaPer4	NMCMS_05/18/2022_SantanaPer6	NMCMS_05/25/2022_SantanaPer2	NMCMS_05/25/2022_SantanaPer3	NMCMS_05/25/2022_SantanaPer4	NMCMS_05/25/2022_SantanaPer6	RSJHS_03/22/2022_JohnsonPer2	RSJHS_03/22/2022_JohnsonPer4							Total Percentage
10	12	12	5	6	15	9	9	11	4	9	5	8	6	7	7	5	3						143	46%
5	9	15	12	10	6	8	7	8	11	11	9	8	11	10	11	9	6						166	54%
1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0						1	0%
16	21	27	17	16	21	17	16	19	15	20	14	16	17	17	18	14	9	0	0	0	0	0	310	100%
0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0						0	0%
8	0	8	0	8	8	0	0	0	0	0	0	0	0	0	0	0	0						32	10%
7	15	15	9	8	13	12	7	6	6	8	10	5	9	4	8	0	0						142	46%
0	6	4	7	0	0	5	9	13	9	12	4	11	8	13	10	2	0						113	36%
0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	2	1						4	1%
0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	6	5						11	4%
0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	1						3	1%
0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0						0	0%
0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0						1	0%
1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	2						4	1%
16	21	27	17	16	21	17	16	19	15	20	14	16	17	17	18	14	9	0	0	0	0	0	310	100%
12	8	26	15	15	19	16	14	17	14	19	13	16	12	17	16	12	6						267	86%
2	0	1	0	1	0	0	2	2	1	1	1	0	4	0	1	0	0						16	5%
0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0						0	0%
0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0						1	0%
0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0						0	0%
0	0	0	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0						2	1%
0	3	0	1	0	2	1	0	0	0	0	0	0	0	0	0	0	0						7	2%
2	10	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	3						17	5%
16	21	27	17	16	21	17	16	19	15	20	14	16	17	17	18	14	9	0	0	0	0	0	310	100%

16 presentations at NMCMS, 287 students 2 presentations at Rancho San Juan, 23 students

North Monterey County Middle School

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21		
NMCMS_03/10/2022_SantanaPer1	NMCMS_03/10/2022_SantanaPer2	NMCMS_03/10/2022_SantanaPer4	NMCMS_03/10/2022_SantanaPer6	NMCMS_03/17/2022_SantanaPer1	NMCMS_03/17/2022_SantanaPer2	NMCMS_03/17/2022_SantanaPer4	NMCMS_03/17/2022_SantanaPer6	NMCMS_05/19/2022_SantanaPer2	NMCMS_05/19/2022_SantanaPer3	NMCMS_05/19/2022_SantanaPer4	NMCMS_05/19/2022_SantanaPer6	NMCMS_05/26/2022_SantanaPer3	NMCMS_05/26/2022_SantanaPer4	NMCMS_05/26/2022_SantanaPer6								Total Percentage
11	11	8	5	7	12	14	10	11	5	8	7	6	8	7							130	47%
4	10	14	12	10	6	8	7	8	12	11	9	10	10	13							144	52%
0	0	0	1	0	0	0	0	0	0	0	0	0	0	0							1	0%
15	21	22	18	17	18	22	17	19	17	19	16	16	18	20	0	0	0	0	0	0	275	100%
Age																						
0	0	0	0	0	0	0	0	0	0	0	0	0	0	0							0	0%
9	0	8	0	8	8	0	0	0	0	0	0	0	0	0							33	12%
6	16	11	10	9	10	17	7	7	6	7	10	10	4	9							139	51%
0	5	3	6	0	0	5	10	12	11	12	6	6	14	11							101	37%
0	0	0	1	0	0	0	0	0	0	0	0	0	0	0							1	0%
0	0	0	0	0	0	0	0	0	0	0	0	0	0	0							0	0%
0	0	0	0	0	0	0	0	0	0	0	0	0	0	0							0	0%
0	0	0	0	0	0	0	0	0	0	0	0	0	0	0							0	0%
0	0	0	0	0	0	0	0	0	0	0	0	0	0	0							0	0%
0	0	0	1	0	0	0	0	0	0	0	0	0	0	0							1	0%
15	21	22	18	17	18	22	17	19	17	19	16	16	18	20	0	0	0	0	0	0	275	100%
Ethnicity																						
0	0	0	0	0	0	0	0	0	0	0	0	0	0	0							0	0%
11	10	22	17	15	16	20	15	17	15	18	14	13	18	18							239	87%
2	1	0	0	1	0	0	2	2	2	1	2	3	0	1							17	6%
0	0	0	0	0	0	0	0	0	0	0	0	0	0	1							1	0%
0	0	0	0	0	0	0	0	0	0	0	0	0	0	0							0	0%
0	0	0	0	1	0	0	0	0	0	0	0	0	0	0							1	0%
0	4	0	0	0	2	2	0	0	0	0	0	0	0	0							8	3%
2	6	0	1	0	0	0	0	0	0	0	0	0	0	0							9	3%
15	21	22	18	17	18	22	17	19	17	19	16	16	18	20	0	0	0	0	0	0	275	100%

15 presentations, 275 students

TEEN POSTPONE PREGNANCY
monterey county health department

ATTENDANCE FORM

Site Name: _____ **Teacher/Coordinator Name:** _____

Period # _____ **Presentation Date:**_____ **Name of Presentation:**_____

Name of Presenters: _____

***Race/Ethnicity:** **AA** – African American **L** – Latino/Hispanic **W** – White **A** – Asian **AI** – American Indian **PI** – Pacific Islander **O** – Other/Multi-Cultural

#	**Name** (First and Last) *Nombre(Primer y Apellido)*	**Age** *Edad*	**Gender** *Género*	***Race** *Raza*
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				

The POSTPONE Alisal High Student Mentors will be attending one full day training on October 15, 2021. Topics to be covered during the fall include: Healthy relationships, how to make good decisions, dating abuse, mental health awareness and services.

In class presentations will be at the end of October and November to the freshmen seminar classes.

Please sign below if you give permission to your student who is in good standing in your class, to attend training and present. It will be the student's responsibility to notify you of the date they will be presenting. Your signature acknowledges your consent for the student to participate and you are agreeing that the student will be able to make up any assignment they miss due to the presentation.

Please contact Ms. Cleaves, Room 535
Or Emiko Torres at MCHD 831-755-4629 torrese@co.monterey.ca.us if you have any questions. Thank you!
^^

Name: ______________________________ **ID#:** _____________
By signing you acknowledge that the student has permission to present during your class period. The student will check in with you for any missed work.

Period	Class	Grade	Citizenship	Teacher	Signature
1					
2					
3					
4					
5					
6					

POSTPONE

Meetings every other Tuesday @ EAHS!!!!

- Peer Education
- Youth Leadership
- Community service hours
- Health Promotion

For more information:

Emiko Torres

831-755-4649

Or Stop by Ms. Jefferson's class

TEEN POSTPONE PREGNANCY

monterey county health department

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TEEN POSTPONE PREGNANCY

monterey county health department

Family PACT
Planning • Access • Care • Treatment
www.familypact.org

Salinas:
- **Alisal Health Center**
  (831) 769-8870, 559 E. Alisal Suite 202, 93906
- **Clinica de Salud**
  (831) 757-1365, 219 N. Sanborn Rd., 93906
- **Clinica de Salud**
  (831) 757-6237, 950 Circle Drive, 93906
- **Laurel Family Practice**
  (831) 755-4123, 1441 Constitution Blvd, Bldg. 400, 3rd Floor, 93906
- **Planned Parenthood Mar Monte**
  (831) 758-8261, 316 N. Main Street, 93906

Marina:
- **Monterey County Health Clinic at Marina**
  (831) 883-7558, 3155 De Forest Road, 93933

Seaside:
- **Seaside Family Health Center**
  (831) 899-8100, 1150 Fremont Blvd., 93955
- **Planned Parenthood Mar Monte**
  (831) 583-6700, 625 Hilby Ave, 93955

Castroville:
- **Clinica de Salud**
  (831) 633-1514, 10561 Merritt Street, 95012

Soledad:
- **Clinica de Salud**
  (831) 678-0881, 799 Front Street, 93960
- **Soledad Medical Clinic**
  (831) 678-2665, 600 Main Street, 93960

Greenfield:
- **Clinica de Salud**
  (831) 674-5344, 808 Oak Ave, 93927

King City:
- **Mee Memorial Clinic**
  (831) 385-7100, 210 Canal Street, 93930
- **Clinica de Salud**
  (831) 385-5944, 122 San Antonio Drive, 93930

NOTICE: Inclusion or exclusion of clinics in this directory does not imply recommendation or endorsement by MCHD or Family Pact. Please note that all information is subject to change. Contact 831-755-4695 for revisions. Revised on October 06, 2020.

Ciudate

Teen Pregnancy
Prevention Programs

Post-Poned Pregnancy

Monterey County Health Department
1441 Schilling Pl 1st Floor, Salinas, CA 93901
Emiko Torres Phone: 831-755-4649
torrese@co.monterey.ca.us

Crisis Hotlines

National Domestic Violence Hotline	800-799-7233
National Human Trafficking Hotline	888-373-7888
Poison Control	800-222-1222
Monterey County Rape Crisis (Salinas)	831-424-4357
24Hr (Monterey)	831-375-4357
YWCA of Monterey County (24Hr)	831-372-6300
	831-757-1001
Suicide Prevention Hotline	877-663-5433
National Suicide Prevention Hotline	800-273-8255

Mental Health Services

Behavioral Health Services CHOMP	831-625-4600
Monterey County Mental Health Access	888-258-6029
Monterey County Mental Health	831-755-4111

HIV Testing/ Services

Access Support Network	831-975-5016
Opus Clinic (Chomp)	831-625-4972
NIDO Clinic Natividad	831-796-1770
Monterey County HIV/ AIDS Services	831-755-4626

Drug & Alcohol Services

Al-Anon & ALA Teen (Spanish)	831-424-6207
(English)	831-373-2532
Alcoholics Anonymous (Salinas)	831-424-9874
(Monterey)	831-373-3713
Community Human Services	831-658-3811
Door to Hope	831-422-6226
Genesis House	831-899-2436
Off Main Clinic	831-424-4828
Sun Street Centers	831-753-5135
Syringe Exchange Program (ASN)	831-975-5016

Adoption Services

Kinship Center	831-455-9965
Family to Family	800-850-0006
Family Children Services	831-755-4475

If you are in need of other services not listed please call

211

Monterey County

Notice: Inclusion or exclusion of services in this directory does not imply recommendation or endorsement by MCHS. Please note all information is subject to change. Contact 831-755-4649 for revision. Revised on 12/09/19.

Date: _____ Period: _____ School: _____

Postpone Peer Health Education
Healthy Relationships

1. True or False (Circle one)
   To make a healthy decision, you must list your options and gather information.

2. How can you tell if you or someone is in an unhealthy relationship? (Circle one)
   a) Communication with one another
   b) Trust each other
   c) Checks your phone
   d) Respect each other's space

3. What is not a sign of reproductive coercion? (Circle one)
   a) Interfering with birth control
   b) Controlling outcome of pregnancy
   c) Pressuring partner to have unprotected sex
   d) Using condoms consistently and correctly

4. True or False (Circle one) The Monterey Rape Crisis Center offers resources for abusive relationships.

5. True or False (Circle one) Monterey County Behavioral health offers mental health services for teens?

Date: _____ Period: _____ School: _____

Postpone Peer Health Education
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1. True or False (Circle one)
   To make a healthy decision, you must list your options and gather information.

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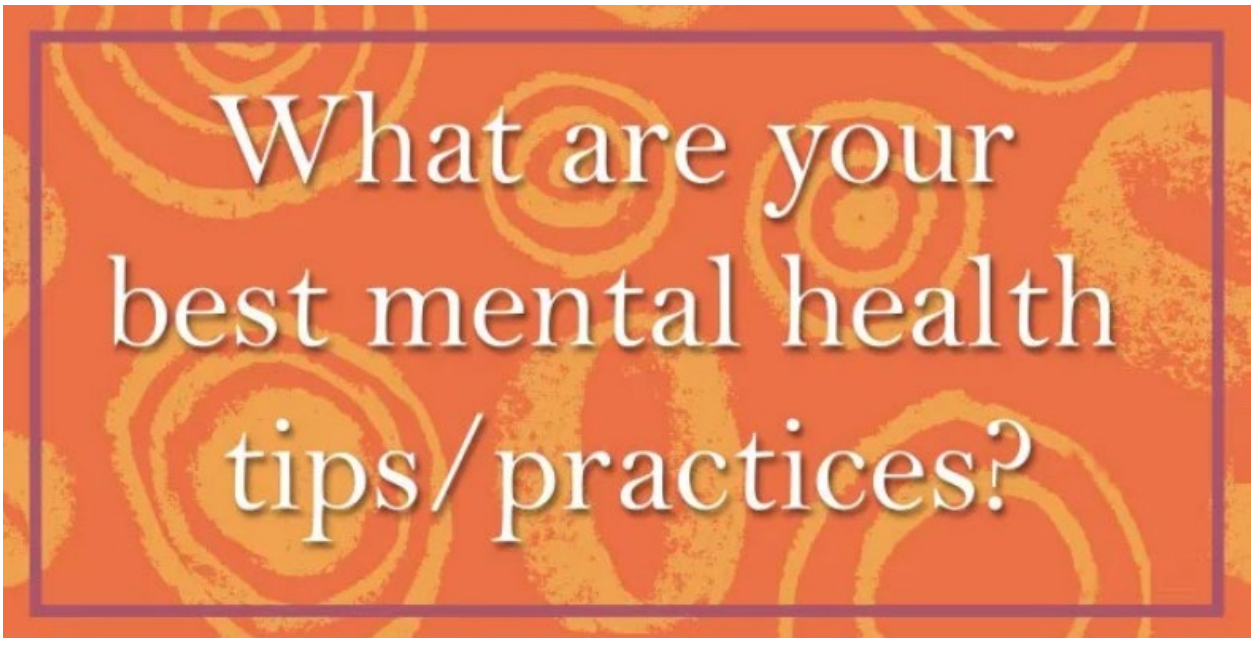
   h) Using condoms consistently and correctly

4. True or False (Circle one) The Monterey Rape Crisis Center offers resources for abusive relationships.

5. True or False (Circle one) Monterey County Behavioral health offers mental health services for teens?

Sample Posts


WHO DO I CALL?
FOR MENTAL HEALTH IN MONTEREY COUNTY?
1-888-258-6029



Community Human Services

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Program 7 - Micro Innovation Report

____Q1____

September 16, 2021 – Communications Manager facilitated presentations to the Migrant Education Program (MEP) districts of Chualar, Gonzalez and Santa Rita. Spoke to MEP parents about no cost mental health services for uninsured or those with Medi-Cal. CHS and MEP have partnered to distribute Spanish language mental health materials to hard-to-reach migrant families, to connect them with counseling support provided by Community Human Services. Estimated reach: 600.

____Q2____

October – December, 2021 – Tricolor Radio "Free Mental Health Counseling" Spots:

> *"COMMUNITY HUMAN SERVICES INVITA A LOS RESIDENTES SIN SEGURO DEL CONDADO DE MONTEREY A INSCRIBIRSE PARA RECIBIR CONSEJERIA GRATUITO PARA EL BIENESTAR MENTAL. ESTARAN DISPONIBLES CONSEJEROS BILINGUES PARA HABLAR SOBRE LA SALUD MENTAL, EL MENAJO DE ESTRES, DEPRESION, ANSIEDAD, Y BIENESTAR. NO SE PIERDEN ESTA OPORTUNIDAD. PARA PROGRAMAR UNA AVALUACION Y SERVICIOS SIN COSTO, LLAME AL 8-3-1—7-5-7—7-9-1-5."*

Analytics: Adults 18+ (Primary)
Impressions: 990,000
Net Reach: 55,400

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Community Human Services

Free Mental Health Campaign
2021

Station	Program	Time	Len.	Mon	Tue	Wed	Th	Fri	Sat	Sun	# of Wks	# of spots a week	Rate	Weekly Cost	Total Cost
KLOK	Early Morning Drive	5a-6a	30	x	x	x	x	x			9	4	$ 11	$ 44	$ 396
KLOK	Morning Drive	6a-10a	30	x	x	x	x	x			9	10	$ 15	$ 150	$ 1,350
KLOK	Midday	10a-3p	30	x	x	x	x	x			9	10	$ 17	$ 170	$ 1,530
KLOK	Afternoon Drive	3p-7p	30	x		x		x			9	3	$ 27	$ 81	$ 729
KLOK	Bonus on Mo-Fr ROS	6a-12a	30	x	x	x	x	x	x	x	9	15	$ -	$ -	$ -
	KLOK Totals											42		$445	$4,005

Air Dates: 10/15/21 – 12/15/21

TOTAL BREAKDOWN:
Total number of spots on KLOK: 42x a week X 9 weeks = 348 Total Spots
15 weekly bonus spots included
Total investment: $4,005

_____Q3_____

February – March, 2022

The MCOE Migrant Education Program (MEP) Manager invited CHS to provide 5 mental health focused workshops to parents and students. Presentations were scheduled as follows:

March 3, 2022	Gonzales High School, Gonzales
March 30, 2022	Del Rey School, King City
March 17, 2022	Greenfield High School, Greenfield
March 24, 2022	Santa Rita Elementary School
April 4, 2022	San Vicente, Soledad

Each workshop covered the following topics:

1. Identify the signs of stress and implement stress reduction practices
2. Implement mindfulness practices
3. Understand appropriate child and adolescent development (parents)
4. Understand the impacts of anxiety and depression on students' academic achievement (parents)
5. Understand the importance of healthy eating and exercise practices

Interested parties received fliers and were referred to utilize our no-cost short-term mental health counseling for uninsured individuals. Estimated reach: 800.

MEP Point of Contact:
Efrain Magallanes
Migrant Education Program, Manager
Monterey County Office of Education
901 Blanco Circle, Salinas, CA 93912
Desk: 831.755.6467 | Cell: 831.229.8680
emagalla@montereycoe.org

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Program 7 - Micro Innovation Report (2022)

_____Q4/Q1_____

June 2022-September 2022 – Community Human Services facilitated campaigns with La Preciosa and Tricolor radio stations in a "Lunchtime Giveaway" promotion to disseminate mental health information and free mental health services to Monterey County Latino/migrant families and farmworkers. The stations conducted bi-weekly contests to choose an Ag group of field workers to receive free lunch in the field and "Mental Health Gift Packs". Lunchtime giveaways were distributed by the station, the CHS Communications Manager, and other CHS staff in attendance.

The promotional activities were very successful: 9 lunchtime events were held during this period (6 in partnership with La Preciosa and 3 in partnership with Tricolor). Approximately 40 Mental Health Gift Packs and lunches were distributed per event to reach approximately 360 migrant farmworkers total. Giveaway events were held at the following farms:

- Camarillo Harvesting / South Salinas
- Sakai Farms / Spreckels
- The Growers Co. / Gonzales
- Braga Ranch / Soledad
- Carrazco Farms / Gonzales
- Mariani Farms /Castroville
- Tanimura & Antle / Salinas
- Merrill Farms / Salinas
- Oasis Berry Farms /Salinas

Mental Health Gift Packs were also disseminated at the Artichoke Festival on 6/11, and during both days of the Salinas Rodeo on 7/21 and 7/22.

- Artichoke Festival (giftpacks disseminated): 100
- Salinas Rodeo (giftpacks disseminated): 500 *(over 27,000 individuals attended the event)*

Targeted radio and Facebook mental health and cross-promotional ads ran from 6/1 – 9/30.

Facebook Campaign Data:

- Facebook Ad Impressions (6/1-10/3): 539,000
- Facebook Ad Reach (6/1-10/3): 151,000

Radio Ad Copy (Tricolor, IHeart, and La Preciosa):

"LA AGENCIA, COMMUNITY HUMAN SERVICES, INVITA A LOS RESIDENTES DEL CONDADO DE MONTEREY, SIN SEGURO MEDICO, A INSCRIBIRSE PARA RECIBIR CONSEJERÍA GRATUITO PARA EL BIENESTAR DE SALUD MENTAL. CONSEJEROS BILINGUES ESTARÁN DISPONIBLES PARA HABLAR SOBRE LAS SALUD MENTAL, EL MANEJO DE ESTRES, DEPRESION, ANSIEDAD, Y BIENESTAR. NO SE PIERDEN ESTA OPORTUNIDAD. PARA PROGRAMAR UNA EVALUACIÓN Y SERVICIOS SIN COSTO, LLAMEN A 831.757.7915 o 831.394.4622."

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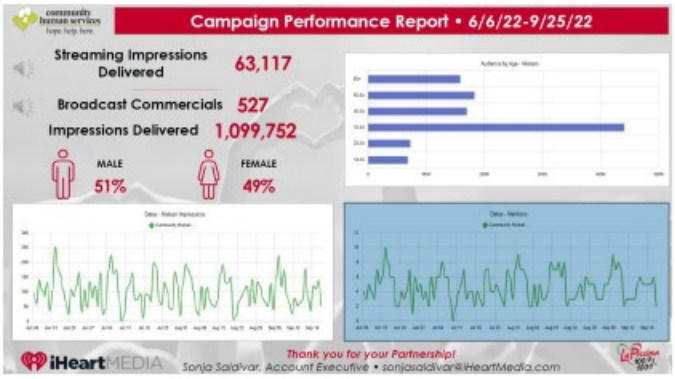
IHeart Campaign Data:



community human services
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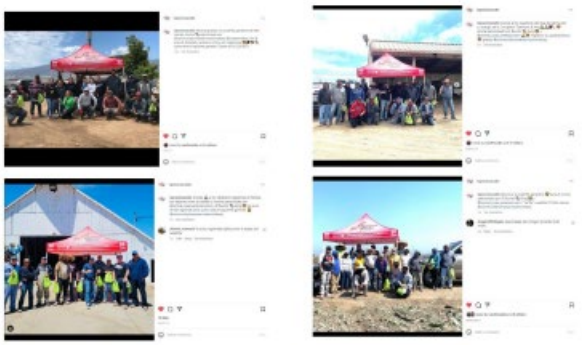
El Mañanero



KLOK/Tricolor Campaign Data:

KLOK/Tricolor Campaign Data (continued):

Community Human Services 2022

TAPSCAN

From: Maria Palacio
Phone: (831) 840-4806
Email: mpalacio@arbitron.com
10/12/2022 1:32 AM

Schedule Grand Totals: 8 Weeks

Stations	Spots	Unit Rate	Total Cost	Average Rating	Schedule Cume Persons	CPP	CPM	GRP's	Frequency	Net Reach	Ols
Radio Total	360	$15.28	$5,500.00	1.3%	97,200	$11.98	$4.93	459.2	13.4	68,600	1,131,000
KLOK-FM	264	$19.38	$5,116.00	1.0%	84,300	$11.14	$4.51	459.2	14.4	79,700	1,131,000
KLOK-FM Stream	96	$4.00	$384.00	0.0%	0	$0.00	$0.00	0.0	0.0	0	0

Detailed Sourcing Summary

Radio Market: MONTEREY-SALINAS-SANTA CRUZ
Survey: Nielsen Radio August 2022 (Jul4 - Aug4)
Geography: Metro
Daypart: Multiple Dayparts Used

Demo/Intab Populations:

Age/Gender	Socioeconomic	Population	Intab
Adults 18+ (Persons)	Blind + Hispanics/All	245,200	600

Stations User Selected
Additional Stations - - Estimates not reported because the station was not reported in the selected survey.

Estimates reported for dayparts which start and end between 12m and 5a are based on the 5a-5a broadcast day. Estimates for all other dayparts are based on the 12m-12m calendar day.
Please note: The intab reported is for the full twelve weeks of the survey. Users should note that reports run on fewer than twelve weeks are based on smaller sample sizes.
Stations qualify to be reported if they have received credit for five or more minutes of listening and meet a minimum reporting standard of 0.1 AQH unrounded rating in the Metro survey area, Monday-Sunday 6AM-Midnight, during the survey period. If a current Nielsen client does not meet this minimum reporting standard, Nielsen will report the station as long as credited listening is received from at least one diary keeper.
Estimates are derived from the diaries that provided the audience data for the Nielsen Radio Market Report and are subject to the qualifications and limitations stated in that Report. The TAPSCAN Web software product is accredited by the Media Rating Council and reports both accredited and non-accredited data. For a list of the accredited and non-accredited Nielsen radio markets and data available through TAPSCAN, click here: http://www.arbitron.com/downloads/MRC_Accredited_Services_Markets.pdf
The Reach and Frequency Model utilized by Nielsen is formulated on the bases of the Harris Model, a Linear Frequency reach-and-frequency model, and the Slide Rule audience (curve) growth model.

MONTEREY COUNTY
BEHAVIORAL HEALTH

Avanzando Juntos Forward Together

PSYCHIATRIC ADVANCE DIRECTIVES MULTI-COUNTY COLLABORATIVE INNOVATIONS REPORT FY 2021-2022

Prepared by:

EVALCORP
Measuring What Matters℠

Contents

Introduction

This is the first Annual Innovation Project Report for the Monterey County component of the Multi-County Psychiatric Advance Directives (PADs) Innovation Project. On June 24, 2021, the Mental Health Services Oversight and Accountability Commissions (MHSOAC) approved the use of Mental Health Services Act Innovation Component funding for Monterey County Behavioral Health (MCBH) and four other counties to implement the PADs Innovation Project. This report pertains to activities that took place during FY 2021-2022.

In accordance with Title 9 California Code of Regulations (9 CCR § 3580.010), a report is to be submitted to the MHSOAC before December 31 following the conclusion of the first fiscal year of project implementation. This report has been developed to provide the MHSOAC and Monterey County stakeholders with a status update on this project. Per Title 9 California Code of Regulations (9 CCR § 3580.010), the contents of this Annual Innovation Report shall include updates on the following:

- Whether and what changes were made to the Innovation Project during the reporting period and the reasons for changes.
- Available evaluation data, including outcomes of the Innovation Project and information about which elements of the Project are contributing to outcomes.
- Program information collected during the reporting period, including the number of participants and demographics of participants served.
- Any other data the County considers relevant.

Project Overview

The PADs Innovation Project is a multi-county collaboration that aims to improve the quality of mental health services by altering an existing practice in the mental health field. Specifically, the PADs Innovation Project will partner with stakeholders, advocacy groups, peers, and others to develop training resources and a "toolkit" in multiple languages, a standardized Psychiatric Advance Directive (PAD) template, a PAD accessibility platform, and recommendations for statewide PAD legislation, policy, and procedures. Counties will identify priority populations to utilize PADS and work towards implementation.

The Problem

Californians with mental illness face high recidivism rates, non-voluntary hospitalization, homelessness, and incarceration. In psychiatric emergencies, it may be challenging or impossible to engage with individuals in even the most basic conversations about symptoms, diagnosis, treatment, and care preferences. Psychiatric Advance Directives (PADs) are legal tools that may be used in these instances to ensure a person's preferences are honored and

increase the quality of care within mental and physical health and justice-involved settings. A PAD allows a person in a mental health crisis to legally retain their decision-making capacity by choosing supporters to help advocate for their choices. PADs are legal documents in which a supporter is identified and entrusted with upholding the decisions and directions in the event the individual experiences a mental health crisis.

Despite the federal Center for Medicare and Medicaid Services recommendation that PADs be used as part of psychiatric care, California does not currently have a specific statute encouraging or recognizing PADs. There is no standardized PAD template, and PADs are often written with a focus on physical rather than mental health. Moreover, inconsistencies make the process confusing for consumers and pose challenges to compliance for providers.

The Solution

Since the 1990s, PADs have been implemented to various extents throughout the US and worldwide. This tool has been shown to improve outcomes, treatment satisfaction, and recidivism rates while also boosting community collaboration, increasing trust in mental health care services, and providing consumers with greater self-determination. However, PADs remain underutilized, and there are barriers to widespread adoption, including a general lack of awareness, perceptions of the process as cumbersome, skepticism that a PAD will be honored, and the absence of a central portal for PADs storage, access, and retrieval.

The PADs Innovation Project is a multi-county collaboration that will expand on a prior PADs project to address unmet needs across California. The project seeks to foster community collaboration, develop standardized trainings and templates, facilitate the creation and utilization of PADs, and lay the groundwork for legislative changes.

Project Goals

This multi-county collaborative project aims to establish the infrastructure for sustainable PADs usage in California. Project goals are described below:

- Engage the community, consumers, peers, families, consumer advocacy groups, law enforcement (LE), emergency departments, inpatient units, and the judicial system.
- Develop community-wide standardized training for understanding, accessing, recognizing, and implementing PADs within the Mental Health Plan, crisis centers, hospitals, LE, homeless services, and transitional-aged youth (TAY) services.
- Create a standardized PAD template.
- Train clinicians, community providers, peers, and others; and create standardized training for future use.

- Draft and advocate for legislation enabling PAD use, accessibility, adherence, and sustainability.
- Create a statewide PADs Technology Platform.
- Evaluate the impact of PADs on consumer outcomes.

Monterey County also identified project goals specific to the County's needs:

- Increase consumers' individual wellness through the use of PADs.
- Reduce incarceration/criminal justice involvement resulting from a crisis.
- Reduce long-term hospitalization rates by increasing adherence to treatment plans.
- Reduce recidivism among clients by minimizing gaps in care.
- Reduce high utilization of services.
- Increase coordination of resources (e.g., warm hand-offs, clear communication).

Resources

The PADs Innovation Project plan indicates the following personnel will be used to execute the project in Monterey County:

Job Title	Responsibilities
Program Coordinator	Project coordination, PADs product development review, and project evaluation and reporting
Clinical Therapist	PADs Team implementation
Administrative Management Intern	Administrative support, evaluation, and reporting
Behavioral Health Bureau Administrator	Implementation planning, vendor procurement, and PADs project development review
Behavioral Health Services Manager	Implementation planning, clinical staff oversight, PAD product development review
Quality Improvement Services Manager	Implementation planning, technology integration coordination, and evaluation
IT Services Manager	Technology integration planning and oversight, and PAD product development review
Behavioral Health Unit Supervisor	Implementation planning, clinical staff coordination, and PAD product development review
Accountant	Fiscal accounting and reporting

Epidemiologist	Project evaluation

Timeline

The PADs Innovation Project is planned to span four years, in accordance with the Title 9 California Code of Regulations (9 CCR § 3910.010). The original timeline for key phases is as follows:

Year One	Year Two
Concepts Forward Consulting · Organize all counties' efforts · Identify Scope of Work tasks for all contractors to complete within year one · Interface with counties and contractors · Conduct and participate in all Stakeholder meetings · Mitigate challenges · Create Scope of Work, Performance Agreements and financial oversight as needed · Assist counties with decision making · Report out to counties, state, and stakeholders as needed	**Concepts Forward Consulting** · Organize all counties' efforts · Identify Scope of Work tasks for all contractors to complete within year two · Interface with counties and contractors · Conduct and participate in all Stakeholder meetings · Mitigate challenges · Enforce all scope of work and performance agreements. · Assist counties with decision making · Report out to counties, state, and stakeholders as needed
Laurie Hallmark (Hallmark Compass) · Participate in statewide meetings · Lead the discussion to create a PAD template · Participate in discussion for "Informational Training Videos" · Assist in identifying PADs Teams · Present Statewide informational sessions · Present county-specific informational sessions · Assist in legislation advocacy · Training on how to obtain PADs clients · Participate in training material creation (Train the Trainer) · Assist with standardized training materials · Participate in data integration discussion	**Laurie Hallmark (Hallmark Compass)** · Participate in statewide meetings · Lead the training of PAD Teams · Lead Train the Trainer for Peers/PADs Implementation · Continue county-specific informational sessions · Micro-train county-specific providers (peers, clinicians, contractors) to provide PADs · Assist in legislation advocacy · Provide 1:1 technical support to counties · Assist with data integration discussion

Idea Engineering · Participate in statewide meetings · Assist with PADs Identity & Guidelines · Create Introductory Videos · Create Training Videos · Create Form Design	**Idea Engineering** · Participate in statewide meetings · Finalize Communications Package · Create PADs Identification Materials for consumers · Provide county-specific technical support
RAND · Participate in stakeholder meetings · Participate in statewide meetings · Provide 1:1 technical support to counties for evaluation priorities	**RAND** · Participate in stakeholder meetings · Participate in statewide meetings · Conduct focus groups with county implementors and Train the Trainer/Peers · Create an interim report · Provide technical support
Technology Platform · Engage in technology conversations and planning · Lead robust Stakeholder meetings · Identify interoperability, access needs · Identify what the platform backend, front end, and user interface will be · Provide additional information to all counties as requested	**Technology Platform** · Begin to build the PADs Platform · Identify PADs template and video upload needs

Year Three	Year Four
Concepts Forward Consulting · Organize all counties' efforts · Identify Scope of Work tasks for all contractors to complete within year three · Interface with counties and contractors · Conduct and participate in all Stakeholder meetings · Mitigate challenges · Assist counties with decision making · Report out to counties, state, and stakeholders as needed · Lead legislative efforts, working with interested agencies and community groups	**Concepts Forward Consulting** · Organize all counties' efforts · Identify Scope of Work tasks for all contractors to complete within year four · Interface with counties and contractors · Conduct and participate in all Stakeholder · meetings · Mitigate challenges · Assist counties with decision making · Report out to counties, state, and stakeholders as needed · Follow legislative efforts · Write Phase Two Innovations PADs Statewide Cloud-based Data project

Laurie Hallmark (Hallmark Compass) · Participate in statewide meetings · Provide 1:1 technical Support to counties · Assist in legislation advocacy	**Laurie Hallmark (Hallmark Compass)** · Participate in statewide meetings · Provide 1:1 technical Support to counties · Participate in the final report development and statewide presentations
Idea Engineering · Provide county-specific technical support	**Idea Engineering** · Provide county-specific technical support · Create a Project Documentary video · Participate in the final report development and statewide presentations
RAND · Conduct focus group(s) with consumers · Conduct survey(s) to assess consumer experience · Aggregate data · Conduct analysis · Provide technical support · Participate in statewide meetings	**RAND** · Aggregate final data · Conduct final analysis · Provide final evaluation report · Participate in the final report development and statewide presentations
Technology Platform · Upload all templates and videos · Meet with consumer groups to discuss access and consent needs and parameters · Test Beta platform examples · Upload PADs on a pilot basis (Quarter 4)	**Technology Platform** · Continue to upload PADs on a pilot basis · Identify ongoing needs to complete statewide access · Pilot QR Code and webpage portal · Seek and/or obtain licensing fees/funding for sustainability

Budget

There was no spending to report in FY 2021-2022. The PADs Innovation Project has a total approved budget of $16,515,147.00, with $1,978,237.00 approved in Monterey County specifically. The local county budget is allocated as follows:

Budget Category	**Year 1**	**Year 2**	**Year 3**	**Year 4**	***Total***
Personnel Salaries	$115,827	$119,302	$122,881	$126,568	*$484,578*
Direct Costs	$371,563	$357,706	$353,857	$353,427	*$1,436,552*
Indirect Costs	$12,455	$12,829	$13,214	$13610	*$52,107*
Equipment	$5,000				*$5,000*
Total	***$504,845***	***$489,837***	***$489,952***	***$493,605***	***$1,978,237***

Project Updates and Changes in FY 2021-2022

Although the PADs Innovation Project only met some of the goals initially set for the first fiscal year (FY 2021-2022), the project overcame numerous challenges to make significant achievements.

The project's first objective was to contract with a fiscal intermediary to meet the counties' request for transparency with oversight of their funding. The intermediary used in prior work—CalMHSA, a statewide Joint Powers Authority (JPA)—opted not to participate in the statewide portion of this project and instead contracted only with Fresno County. Syracuse University (SU) was identified and onboarded as the new fiscal intermediary.

Between July 1, 2021 and April 30, 2022, the five participating counties collaborated with SU and Concepts Forward Consulting (CFC) to create a standard Master Agreement that includes a scope of work and budget narrative. In addition to a standardized agreement, each county required county-specific protocols, contract language, and procedures (Appendix B). This process was time-consuming, as each draft needed to be reviewed by individual county stakeholders. Moreover, BOS approval was required after an agreement was finalized. Though the task was lengthy and challenging, the accomplishment was monumental. This standardized Master Agreement provides a tool that any county can pick up and use, significantly reducing the required time for contracting. In the future, this document could be included in all additional county Mental Health Plans for contracting approval, creating a statewide form.

Because the Master Agreement process took longer than expected, this impacted the project timeline and contractors. CFC and Hallmark Compass began work on the project in March 2022. However, other subcontractors did not start work on this project in FY 2021-2022, as previously planned (e.g., RAND, Idea Engineering). Updates on these contractors' work progress will be provided in the FY 2022-2023 report.

Throughout the initial creation of the PADs Innovation Project and the contract approval process, the counties and CFC met bi-monthly to continue moving the process forward. These 'county-to-county' meetings opened valuable discussions and fostered collaboration.

Finally, counties participated in ancillary activities in addition to the project activities already discussed. For example, each county sent a representative to NAMI California's Annual Conference in October 2021. After the conference, one county representative stated, "that was refreshing and energizing to go back to the beginning and remember why we are doing all of this. I cannot wait to get to that finish line. Go, team!"

The PADs Innovations Project faced numerous challenges and made great strides in FY 2021-2022. Through overcoming these obstacles, important lessons were learned for both this project and future Innovations endeavors. Below are a few examples:

- Projects should expect 6-9 months for contracting after receiving MHSOAC approval.
- Positions cannot be filled until the BOS approves the fiscal spending and contract language. Then, the county hiring process can take an additional nine months.
- Creating a true multi-county collaborative, integrating counties' voices and standards to create equal contract language, is complex and takes significant time.
- Having a project manager with direct county and MHSA experience is essential as counties rely on this individual's expertise.
- Bi-monthly meetings—plus additional meetings with subcontractors and the fiscal intermediary—are essential to ensuring the project progresses.
- Additional training is needed for external county staff and BOS to fully understand the nuances of MHSA and, more importantly, the unique aspects of multi-county collaborations and statewide initiatives.

Evaluation

No consumers were engaged in this project during FY 2021-2022. Therefore, no evaluation data is available for this period.

Future evaluation data may examine the following:

- Training-related outcomes for peers engaged in the PADs Innovation Project (e.g., knowledge, attitudes, perceptions)
- Process outcomes relative to the implementation of PADs (e.g., outreach and number of PADS created, coordination of services and care)
- Consumer experiences with PADS (e.g., client satisfaction, empowerment, autonomy, engagement in treatment, alignment between preferences and treatment received)
- Changes in consumers' individual wellness, criminal justice involvement, long-term hospitalization rates, utilization of services, and recidivism

Appendix A – Approval Letter

[approval letter will be in the pdf file]

Appendix B –Agreement

[Agreement will be added in the pdf file]

MONTEREY COUNTY BEHAVIORAL HEALTH

Avanzando Juntos Forward Together

DIRECTIVAS AVANZADAS PSIQUIÁTRICAS
INFORME DE INNOVACIONES COLABORATIVAS DE VARIOS CONDADOS PARA EL AÑO FISCAL 2021-2022

Preparado por:

EVALCORP
Measuring What Matters℠

Contenido

Introducción

Este es el primer Informe Anual del Proyecto de Innovación para el componente del Condado de Monterey del Proyecto de Innovación de Directivas Avanzadas Psiquiátricas (PADs, por sus siglas en inglés) de múltiples condados. El 24 de junio de 2021, las Comisiones de Supervisión y Responsabilidad de los Servicios de Salud Mental (MHSOAC, por sus siglas en inglés) aprobaron el uso de los fondos del Componente de Innovación de la Ley de Servicios de Salud Mental para la Salud del Comportamiento del Condado de Monterey (MCBH, por sus siglas en inglés) y otros cuatro condados para implementar el Proyecto de Innovación PADs. Este informe se refiere a las actividades que tuvieron lugar durante el año fiscal 2021-2022.

De acuerdo con el Título 9 del Código de Regulaciones de California (9 CCR § 3580.010), se debe presentar un informe al MHSOAC antes del 31 de diciembre después de la conclusión del primer año fiscal de la implementación del proyecto. Este informe ha sido desarrollado para proporcionar al MHSOAC y a las partes interesadas del Condado de Monterey una actualización del estado de este proyecto. Según el Título 9 del Código de Regulaciones de California (9 CCR § 3580.010), el contenido de este informe anual de Innovación incluirá actualizaciones sobre lo siguiente:

- Si se introdujeron cambios en el Proyecto de Innovación durante el período que abarca el informe y qué motivos hubo para el cambio.
- Datos de evaluación disponibles, incluidos los resultados del Proyecto de Innovación e información sobre qué elementos del proyecto están contribuyendo en los resultados.
- Información del programa recopilada durante el período del informe, incluido el número de participantes y la demografía de los participantes atendidos.
- Cualquier otro dato que el condado considere relevante.

Descripción General del Proyecto

El Proyecto de Innovación PADs es una colaboración de varios condados que tiene como objetivo mejorar la calidad de los servicios de salud mental mediante la alteración de una práctica existente en el campo de la salud mental. Específicamente, el Proyecto de Innovación PADs se asociará con las partes interesadas, grupos de defensa, pares y otros para desarrollar recursos de capacitación y un “conjunto de herramientas” en varios idiomas, una plantilla estandarizada de Directiva Anticipada Psiquiátrica (PAD), una plataforma de accesibilidad de PAD y recomendaciones para la legislación, política y procedimientos de PAD en todo el estado. Los condados identificarán las poblaciones prioritarias para utilizar PADs y trabajarán hacia su implementación.

El problema

Los californianos con enfermedades mentales enfrentan altas tasas de reincidencia, hospitalización no voluntaria, falta de vivienda y encarcelamiento. En las emergencias psiquiátricas, puede ser difícil o imposible entablar con las personas incluso las conversaciones más básicas sobre los síntomas, el diagnóstico, el tratamiento y las preferencias de atención. Las directivas psiquiátricas anticipadas (PADs) son herramientas legales que pueden usarse en estos casos para garantizar que se respeten las preferencias de una persona y aumentar la calidad de la atención dentro de la salud mental y física y los entornos relacionados con la justicia. Un PAD permite a una persona en una crisis de salud mental retener legalmente su capacidad de toma de decisiones al elegir defensores para ayudar a abogar por sus elecciones. Los PADs son documentos legales en los que se identifica a un defensor y se le confía la defensa de las decisiones y direcciones en caso de que el individuo experimente una crisis de salud mental.

A pesar de la recomendación federal del Centro de Servicios de Medicare y Medicaid de que los PADs se utilicen como parte de la atención psiquiátrica, California actualmente no tiene un estatuto específico que aliente o reconozca los PADs. No existe una plantilla PAD estandarizada, y los PADs a menudo se escriben con un enfoque en la salud física en lugar de la mental. Además, las inconsistencias hacen que el proceso sea confuso para los consumidores y plantean desafíos para el cumplimiento por parte de los proveedores.

La solución

Desde la década de 1990, los PADs se han implementado en diversos grados en los Estados Unidos y en todo el mundo. Se ha demostrado que esta herramienta mejora los resultados, la satisfacción con el tratamiento y las tasas de reincidencia, al tiempo que aumenta la colaboración comunitaria, aumenta la confianza en los servicios de atención de salud mental y brinda a los consumidores una mayor autodeterminación. Sin embargo, los PADs siguen siendo subutilizados, y existen barreras para la adopción generalizada, incluyendo una falta general de conciencia, percepciones del proceso como engorroso, escepticismo de que se respetará un PAD y la ausencia de un portal central para el almacenamiento, acceso y recuperación de los PADs.

El Proyecto de Innovación de PADs es una colaboración de varios condados que ampliará un proyecto anterior de PADs para abordar las necesidades no satisfechas en todo California. El proyecto busca fomentar la colaboración comunitaria, desarrollar capacitaciones y plantillas estandarizadas, facilitar la creación y utilización de PADs, y sentar las bases para cambios legislativos.

Metas del Proyecto

Este proyecto colaborativo de varios condados tiene como objetivo establecer la infraestructura para el uso sostenible de PADs en California. Los objetivos del proyecto se describen a continuación:

- Involucrar a la comunidad, los consumidores, los compañeros, las familias, los grupos de defensa del consumidor, las autoridades policiales (LE, por sus siglas en inglés), los departamentos de emergencia, las unidades de pacientes hospitalizados y el sistema judicial.
- Desarrollar capacitación estandarizada en toda la comunidad para comprender, acceder, reconocer e implementar PADs dentro del Plan de Salud Mental, centros de crisis, hospitales, LE, servicios para personas sin hogar y servicios para jóvenes en edad de transición (TAY, por sus siglas en inglés).
- Crear una plantilla de PAD estandarizada.
- Capacitar a médicos, proveedores comunitarios, compañeros y otros; y crear capacitación estandarizada para uso futuro.
- Redactar y abogar por legislación que permita el uso, la accesibilidad, la adherencia y la sostenibilidad del PAD.
- Crear una plataforma tecnológica de PADs en todo el estado.
- Evaluar el impacto de los PADs en los resultados del consumidor.

El Condado de Monterey también identificó metas del proyecto específicas para las necesidades del condado:

- Aumentar el bienestar individual de los consumidores mediante el uso de PADs.
- Reducir el encarcelamiento/intervención de la justicia penal como resultado de una crisis.
- Reducir las tasas de hospitalización a largo plazo al aumentar la adherencia a los planes de tratamiento.
- Reducir la reincidencia entre los clientes minimizando las brechas en la atención.
- Reducir la alta utilización de los servicios.
- Aumentar la coordinación de los recursos (p. ej., transferencias amables, comunicación clara).

Recursos

El plan del Proyecto de Innovación de PADs indica que se utilizará el siguiente personal para ejecutar el proyecto en el Condado de Monterey:

Título del trabajo	Responsabilidades
Coordinador del programa	Coordinación del proyecto, revisión del desarrollo de productos de los PADs y evaluación e informes del proyecto
Terapeuta clínico	Implementación del equipo PADs
Practicante de gestión administrative	Apoyo administrativo, evaluación y presentación de informes
Administrador de la oficina de salud del comportamiento	Planificación de la implementación, adquisición de proveedores y revisión del desarrollo del proyecto de PAD
Gerente de servicios de salud del comportamiento	Planificación de la implementación, supervisión del personal clínico, revisión del desarrollo del producto PAD
Gerente de servicios de mejora de calidad	Planificación de la implementación, coordinación de la integración tecnológica y evaluación
Gerente de servicios TI	Planificación y supervisión de la integración de tecnología, y revisión del desarrollo de productos PAD
Supervisor de la unidad de salud del comportamiento	Planificación de la implementación, coordinación del personal clínico y revisión del desarrollo de productos PAD
Contador	Contabilidad y presentación de informes fiscales
Epidemiólogo	Evaluación del proyecto

Línea de Tiempo

El Proyecto de Innovación PAD está planeado para abarcar cuatro años, de acuerdo con el Título 9 del Código de Regulaciones de California (9 CCR § 3910.010). La línea de tiempo original para las fases clave es la siguiente:

Año uno	Año dos
Conceptos de consultoría avanzada · Organizar los esfuerzos de todos los condados · Identificar el alcance del trabajo para que todos los contratistas completen dentro del primer año · Interactuar con condados y contratistas · Llevar a cabo y participar en todas las reuniones de las partes interesadas · Mitigar los desafíos · Crear el alcance del trabajo, los acuerdos de desempeño y la supervisión financiera según sea necesario · Ayudar a los condados con la toma de decisiones · Informar a los condados, estados y partes interesadas según sea necesario	**Conceptos de consultoría avanzada** · Organizar los esfuerzos de todos los condados · Identificar el alcance del trabajo para que todos los contratistas completen dentro del segundo año · Interactuar con condados y contratistas · Llevar a cabo y participar en todas las reuniones de partes interesadas · Mitigar los desafíos · Hacer cumplir todos los acuerdos de alcance de trabajo y desempeño. · Ayudar a los condados con la toma de decisiones · Informar a los condados, estados y partes interesadas según sea necesario
Laurie Hallmark (Hallmark Compass) · Participar en reuniones estatales · Dirigir la discusión para crear una plantilla de PAD · Participar en la discusión de "Videos informativos de capacitación" · Ayudar a identificar equipos de PADs · Estar presente en sesiones informativas en todo el estado · Estar presente en sesiones informativas específicas del condado · Ayudar en la promoción de la legislación · Capacitación sobre cómo obtener clientes de PADs · Participar en la creación de material de capacitación (Capacitar al Capacitador) · Ayudar con materiales de capacitación estandarizados · Participar en la discusión sobre integración de datos	**Laurie Hallmark (Hallmark Compass)** · Participar en reuniones estatales · Dirigir la capacitación de los equipos de PAD · Liderar Capacitar al Capacitador para la implementación de pares/PADs · Continuar con las sesiones informativas específicas del condado · Micro capacitar a los proveedores específicos del condado (compañeros, médicos, contratistas) para proporcionar PADs · Ayudar en la promoción de la legislación · Proporcionar soporte técnico 1:1 a los condados · Ayudar con la discusión sobre la integración de datos
Idea Engeneering · Participar en reuniones estatales · Ayudar con la identidad y las pautas de PADs · Crear videos introductorios · Crear videos de capacitación · Crear diseño de formularios	**Idea Engeneering** · Participar en reuniones estatales · Finalizar paquete de comunicaciones · Crear Materiales de identificación para consumidores de PADs · Proporcionar soporte técnico específico del condado

RAND · Participar en reuniones de partes interesadas · Participar en reuniones estatales · Proporcionar apoyo técnico 1:1 a los condados para las prioridades de evaluación	**RAND** · Participar en reuniones de partes interesadas · Participar en reuniones estatales · Llevar a cabo grupos focales con los implementadores del condado y capacitar al capacitador/compañeros · Crear un informe provisional · Proporcionar apoyo técnico
Plataforma tecnológica · Participar en conversaciones y planificación tecnológica · Liderar reuniones sólidas con las partes interesadas · Identificar la interoperabilidad y las necesidades de acceso · Identificar cuál será el backend, el front-end y la interfaz del usuario de la plataforma · Proporcionar información adicional a todos los condados según lo solicitado	**Plataforma tecnológica** · Comenzar a construir la plataforma PADs · Identificar las necesidades de plantilla y carga de video de PADs

Año tres	**Año cuatro**
Conceptos de consultoría avanzada · Organizar los esfuerzos de todos los condados · Identificar el alcance del trabajo para que todos los contratistas completen dentro del tercer año · Interfaz con condados y contratistas · Llevar a cabo y participar en todas las reuniones de las partes interesadas · Mitigar los desafíos · Ayudar a los condados con la toma de decisiones · Informar a los condados, estados y partes interesadas según sea necesario · Liderar los esfuerzos legislativos, trabajando con agencias interesadas y grupos comunitarios	**Conceptos de consultoría avanzada** · Organizar los esfuerzos de todos los condados · Identificar el alcance del trabajo para que todos los contratistas completen dentro del cuarto año · Interfaz con condados y contratistas · Llevar a cabo y participar en todas las reuniones de las partes interesadas · Mitigar los desafíos · Ayudar a los condados con la toma de decisiones · Informar a los condados, el estado y las partes interesadas según sea necesario · Seguir con los esfuerzos legislativos · Escribir el proyecto estatal de datos de Innovaciones basados en la nube de la fase dos de PADs

Laurie Hallmark (Hallmark Compass) · Participar en reuniones estatales Proporcionar apoyo técnico 1:1 a los condados · Ayudar en la promoción de la legislación	**Laurie Hallmark (Hallmark Compass)** · Participar en reuniones estatales · Proporcionar apoyo técnico 1:1 a los condados · Participar en el desarrollo del informe final y presentaciones en todo el estado
Idea Engeneering · Proporcionar soporte técnico específico del condado	**Idea Engeneering** · Proporcionar soporte técnico específico del condado · Crear un video documental del proyecto · Participar en el desarrollo del informe final y presentaciones en todo el estado
RAND · Llevar a cabo grupos focales con los consumidores · Realizar encuestas para evaluar la experiencia del consumidor · Agregar datos · Realizar análisis · Proporcionar apoyo técnico · Participar en reuniones estatales	**RAND** · Agregar datos finales · Realizar análisis finales · Proporcionar informe de evaluación final · Participar en el desarrollo del informe final y presentaciones en todo el estado
Plataforma tecnológica · Cargar todas las plantillas y vídeos · Reunir con grupos de consumidores para discutir las necesidades y parámetros de acceso y consentimiento · Probar los ejemplos de plataformas Beta · Cargar PADs en forma de prueba (Trimestre 4)	**Plataforma tecnológica** · Continuar cargando PADs en forma de prueba · Identificar las necesidades continuas para completar el acceso en todo el estado · Poner a prueba el Código QR y portal de página web · Buscar y/u obtener la financiación/licencias para la sostenibilidad

Presupuesto

No hubo gastos que informar en el año fiscal 2021-2022. El Proyecto de Innovación PADs tiene un presupuesto total aprobado de $16,515,147.00, con $1,978,237.00 aprobados específicamente en el Condado de Monterey. El presupuesto local del condado se asigna de la siguiente manera:

Categoría de presupuesto	**Año 1**	**Año 2**	**Año 3**	**Año 4**	***Total***
Sueldos personales	$115,827	$119,302	$122,881	$126,568	*$484,578*
Costos directos	$371,563	$357,706	$353,857	$353,427	*$1,436,552*
Costos indirectos	$12,455	$12,829	$13,214	$13,610	*$52,107*
Equipo	$5,000				*$5,000*
Total	***$504,845***	***$489,837***	***$489,952***	***$493,605***	***$1,978,237***

Actualizaciones y Cambios del Proyecto en el Año Fiscal 2021-2022

Aunque el Proyecto de Innovación PADs solo cumplió con algunos de los objetivos establecidos inicialmente para el primer año fiscal (año fiscal 2021-2022), el proyecto superó numerosos desafíos para obtener logros significativos.

El primer objetivo del proyecto fue contratar a un intermediario fiscal para satisfacer la solicitud de transparencia de los condados con la supervisión de su financiación. El intermediario utilizado en el trabajo anterior, CalMHSA, Joint Powers Authority (JPA) en todo el estado, optó por no participar en la parte estatal de este proyecto y, en cambio, contrató solo con el condado de Fresno. La Universidad de Syracuse (SU, por sus siglas en inglés) fue identificada e incorporada como el nuevo intermediario fiscal.

Entre el 1 de julio de 2021 y el 30 de abril de 2022, los cinco condados participantes colaboraron con SU y Concepts Forward Consulting (CFC) para crear un acuerdo marco estándar que incluye un alcance de trabajo y una descripción presupuestaria. Además de un acuerdo estandarizado, cada condado requería protocolos específicos del condado, lenguaje contractual y procedimientos (Apéndice B). Este proceso consumía mucho tiempo, ya que cada borrador debía ser revisado por las partes interesadas del condado individualmente. Además, se requería la aprobación de la BOS después de finalizar un acuerdo. Aunque la tarea fue larga y desafiante, el logro fue monumental. Este Acuerdo Maestro Estandarizado proporciona una herramienta que cualquier condado puede recoger y usar, reduciendo significativamente el tiempo requerido para la contratación. En el futuro, este documento podría incluirse en todos los

planes de salud mental adicionales del condado para la aprobación de la contratación, creando un formulario estatal.

Debido a que el proceso del Acuerdo Marco tomó más tiempo de lo esperado, esto afectó el cronograma del proyecto y los contratistas. CFC y Hallmark Compass comenzaron a trabajar en el proyecto en marzo de 2022. Sin embargo, otros subcontratistas no comenzaron a trabajar en este proyecto en el año fiscal 2021-2022, como se planeó anteriormente (p. ej., RAND, Idea Engineering). Las actualizaciones sobre el progreso del trabajo de estos contratistas se proporcionarán en el informe del año fiscal 2022-2023.

A lo largo de la creación inicial del Proyecto de Innovación PADs y el proceso de aprobación del contrato, los condados y CFC se reunieron bimensualmente para continuar avanzando en el proceso. Estas reuniones de "condado a condado" abrieron discusiones valiosas y fomentaron la colaboración.

Finalmente, los condados participaron en actividades auxiliares además de las actividades del proyecto ya discutidas. Por ejemplo, cada condado envió un representante a la Conferencia Anual de NAMI California en octubre de 2021. Después de la conferencia, un representante del condado declaró: “Fue refrescante y energizante volver al principio y recordar por qué estamos haciendo todo esto. No puedo esperar para llegar a esa meta. ¡Vamos, equipo!”

El Proyecto de Innovaciones PADs enfrentó numerosos desafíos e hizo grandes avances en el año fiscal 2021-2022. Al superar estos obstáculos, se aprendieron lecciones importantes tanto para este proyecto como para los futuros esfuerzos de Innovaciones. A continuación, se presentan algunos ejemplos:

- Los proyectos deben esperar de 6 a 9 meses para la contratación después de recibir la aprobación de MHSOAC.
- Los puestos no se pueden llenar hasta que la BOS apruebe el gasto fiscal y el lenguaje del contrato. Luego, el proceso de contratación del condado puede tomar nueve meses adicionales.
- Crear una verdadera colaboración entre varios condados, integrando las voces y los estándares de los condados para crear un lenguaje contractual igualitario, es complejo y lleva mucho tiempo.
- Tener un gerente de proyecto con experiencia directa en el condado y MHSA es esencial ya que los condados confían en la experiencia de esta persona.
- Las reuniones bimensuales, además de reuniones adicionales con los subcontratistas y el intermediario fiscal, son esenciales para garantizar que el proyecto progrese.
- Se necesita capacitación adicional para que el personal externo del condado y BOS comprendan completamente los matices de MHSA y, lo que es más importante, los aspectos únicos de las colaboraciones en varios condados y las iniciativas estatales.

Evaluación

Ningún consumidor participó en este proyecto durante el año fiscal 2021-2022. Por lo tanto, no se dispone de datos de evaluación para este período.

Los datos futuros de evaluación pueden examinar lo siguiente:

- Resultados relacionados con la capacitación para pares que participan en el Proyecto de Innovación de PADs (p. ej., conocimiento, actitudes, percepciones.)
- Resultados del proceso relativos a la implementación de PADs (p. ej., alcance y número de PADS creados, coordinación de servicios y atención.)
- Experiencias de los consumidores con PADs (p. ej., satisfacción del cliente, empoderamiento, autonomía, participación en el tratamiento, alineación entre las preferencias y el tratamiento recibido.)
- Cambios en el bienestar individual de los consumidores, la participación en la justicia penal, las tasas de hospitalización a largo plazo, la utilización de los servicios, y reincidencia.

Appendix A – Approval Letter

[approval letter will be in the pdf file]

Appendix B –Agreement

[Agreement will be added in the pdf file]

MONTEREY COUNTY
BEHAVIORAL HEALTH

Avanzando Juntos Forward Together

RESIDENTIAL CARE FACILITY INCUBATOR INNOVATIONS REPORT FY2021-2022

Prepared by:

EVALCORP
Measuring What Matters℠

Contents

Introduction

This is the First Annual Innovation Project Report for the Monterey County Innovation Project titled "Residential Care Facility Incubator" (RCFI). On November 1, 2021, the Mental Health Services Oversight and Accountability Commissions (MHSOAC) approved the use of Mental Health Services Act Innovation Component funding for Monterey County Behavioral Health (MCBH) to implement RCFI. This report pertains to activities that took place during FY 2021/2022.

In accordance with Title 9 California Code of Regulations (9 CCR § 3580.010), a report is to be submitted to the MHSOAC before December 31st following the conclusion of the first fiscal year of project implementation. Although the implementation of this project has been delayed, this report has been developed to provide the MHSOAC and Monterey County stakeholders with a status update on this Innovation project. Per Title 9 California Code of Regulations (9 CCR § 3580.010), the contents of this First Annual Innovation Report shall include updates on the following:

- Whether and what changes were made to the Innovation Project during the reporting period and the reasons for changes.
- Available evaluation data, including outcomes of the Innovation Project and information about which elements of the Project are contributing to outcomes.
- Program information collected during the reporting period, including the number of participants and demographics of participants served.
- Any other data the County considers relevant.

Project Overview

The RCFI project aims to promote interagency and community collaboration regarding mental health services and supports by changing an existing practice in the field. Specifically, the RCFI project will increase the availability of residential care facilities for adults experiencing serious mental illness (SMI) in Monterey County and support those facilities in becoming culturally and linguistically responsive. To do this, MCBH will both seek out existing facility operators and engage new property owners that are interested in providing more culturally and linguistically responsive services. Across two phases, the project will develop and deliver the training and support needed to equip property owners to execute and maintain such services successfully.

The Problem

The RCFI project was developed in response to community and consumer feedback citing a need for (a) programming that embraces individuals' cultures and experiences, (b) expanded access and quality care in local communities, especially for homeless adults experiencing SMI, and (c) systems-level change to address the housing crisis. In addition to this feedback from

community members, an internal review of local resources showed insufficient beds for adults with SMI and a lack of culturally and linguistically responsive residential care services.

In recent years, at least three residential care facilities in Monterey County have closed, resulting in a loss of over 50 beds for adults experiencing SMI. When individuals experiencing SMI are released from higher levels of care but do not have suitable housing, this often leads to another mental health crisis and a return to high-level care, institutionalization, or homelessness. Common barriers to opening and maintaining adult residential care facilities include insufficient finances, lack of community buy-in, and staffing challenges.

In addition, an internal review of residential care facilities for adults experiencing SMI in Monterey County determined that these programs were not designed to respond to their residents' cultural and linguistic needs. For example, while Latinos make up 78% of Medi-Cal beneficiaries, no residential care facilities provide services embracing common Latino cultural traditions. MCBH managers estimate that an additional 150 Adults System of Care consumers would benefit from culturally and linguistically responsive residential care facilities.

To address these issues, some counties have implemented programs that assist consumers in transitioning to a lower level of care or have directly addressed the problem of linking consumers to appropriate housing. However, no programs in California appear to have implemented culturally and linguistically relevant residential care facilities for adults experiencing SMI, and there is no readily available information on how to do so.

The Solution

To increase the availability of culturally and linguistically responsive residential care facilities for adults experiencing SMI, the RCFI project will repurpose residential and commercial properties to support residential care clients and rejuvenate existing facilities that are struggling to operate. The project has two phases:

> *Phase I: Research & Planning* – Identify and develop the necessary training and supports to equip property owners to operate residential care facilities that are culturally and linguistically responsive to the needs of the local SMI population.
>
> *Phase II: Implementation* – Educate property owners on how to integrate more culturally and linguistically responsive services into their facility. Provide property owners with training and technical assistance related to operating a small business.

Learning Goals

The RCFI project aims to establish culturally and linguistically responsive housing options for adults experiencing SMI in Monterey County. The current funding is for Phase I of the project; Phase I focuses on researching (a) the challenges facing residential care facility operators, and

(b) the challenges facing individuals from particular cultural groups who are experiencing SMI. Results from this phase will inform materials and infrastructure to train and support property owners in operating successful culturally and linguistically responsive facilities (in Phase II). Learning goals for Phase I are described below.

1. Describe the attributes of and specific needs for culturally and linguistically responsive residential care facilities that serve the SMI population.

2. Ascertain barriers that prevent residential care facilities from being developed and remaining sustainable.

3. Determine the supports necessary to assist property owners who are already integrated into the community and are interested in turning their property into a residential care facility.

4. Outline the support needed to ensure residential care facilities are financially sustainable for property owners.

5. Identify what materials and technical assistance will be required to support implementation in Phase II.

Resources

The RCFI project plan indicates the following personnel will be used to execute Phase I of the project:

Job Title	Responsibilities
Management Analyst II	Function as Innovation Coordinator to provide/support project management, service coordination, communications and outreach, vendor procurement, evaluation, and reporting activities.
Public Health Epidemiologist I	Participate and collaborate with vendor(s) and stakeholders in Phase I to develop an evaluation plan for Phase II implementation.
Behavioral Health Services Manager II	Monitor and approve vendor deliverables and provide technical assistance on service coordination and other matters as needed.
Behavioral Health Aide	Function as peer specialists to ensure Phase I and Phase II activities will be culturally competent and consumer-driven.

Consultant(s)	Provide subject matter expertise in residential care facility certification and management, supportive housing services, cultural and linguistic competency, marketing, and communications. Research and design a compelling and actionable Phase II implementation plan.

Timeline

The complete timeline for this project will not exceed five years, as required by Title 9 California Code of Regulations (9 CCR § 3910.010). Phase I will occur over a period of 2 years:

- *3-6 Months*: Acquire the necessary consultant(s) and/or vendor(s) through a Request for Proposal (RFP) process.
- *12-18 Months*: Consultant(s) and/or vendor(s) will evaluate opportunities and barriers for implementation and create an actionable implementation plan (i.e., Phase II plan) for incubating cultural and linguistically responsive residential care facilities to mitigate housing instability concerns among the SMI population and positively impact mental health outcomes. Activities to be performed will generally include:
    - Identifying cultural/linguistic needs of the population of focus and identifying/informing corresponding tools and training for residential care facility providers to adequately respond to cultural/linguistic needs of the population of focus that may improve retention and outcomes
    - Investigating known and currently unknown challenges experienced by residential care facility operators in Monterey County and California that negatively impact their sustainability, and identifying solutions via technical assistance, training and/or policy change
    - Identifying and recruiting interested property owners
    - Planning with MCBH to establish a strategy for providing client placements and care coordination

Budget

Phase I of the RCFI project has a total approved budget of $792,130, allocated as follows:

Budget Category	**Year 1**	**Year 2**	***Total***
Personnel Salaries	$193,078	$193,078	*$386,155*

Direct Costs	$171,921	$171,921	*$343,842*
Indirect Costs	$31,066	$31,066	*$62,133*
Total	***$396,065***	***$696,065***	***$792,130***

Project Updates and Changes in FY 2021/22

The RCFI project has not yet begun implementation. The release of the Request for Proposal (RFP) to acquire the necessary vendors for this project was delayed due to limited staff capacity within MCBH and the Monterey County Contracts Purchasing Department. No activities were conducted in FY 2021/22, therefore no specific updates on project implementation are available. The RFP will be released in FY 2022/23.

Evaluation Data

No individuals were engaged in this project, and no activities were conducted during FY 2021/22. Therefore, no evaluation data is available for this period.

Future evaluation data may examine:

- Specific needs of individuals experiencing SMI in Monterey County.
- The efficacy of the proposed model of culturally and linguistically responsive residential care facilities.
- The number and characteristics of property owners interested in participating in the project, and their identified needs.
- Consumers' experience and satisfaction as it relates to cultural and linguistic responsiveness of facilities
- Consumer improvement as identified by the number of homeless days, incarceration rates, emergency room visits, symptom management, substance use, interest in education, and other indicators.

Appendix A – Approval Letter

[approval letter will be in the pdf file]

MONTEREY COUNTY BEHAVIORAL HEALTH

Avanzando Juntos Forward Together

INCUBADORA DE CENTROS DE ATENCIÓN RESIDENCIAL

INFORME SOBRE INNOVACIONES

AÑO FISCAL 2021-2022

Preparado por:

EVALCORP

Measuring What Matters℠

Contenido

Introducción

Este es el Primer Informe Anual del Proyecto de Innovación del Condado de Monterey titulado "Incubadora de centros de atención residencial" (Residential Care Facility Incubator, RCFI). El 1 de noviembre de 2021, las Comisiones de Supervisión y Rendición de Cuentas de los Servicios de Salud Mental (Mental Health Services Oversight and Accountability Commissions, MHSOAC) aprobó el uso de fondos del Componente de innovación de la Ley de servicios de salud mental (Mental Health Services Act Innovation Component) para la Salud conductual del condado de Monterey (Monterey County Behavioral Health, MCBH) para implementar RCFI. Este informe se refiere a las actividades realizadas durante el año fiscal 2021/2022.

De conformidad con el Título 9 del Código Normativo de California (9 CCR § 3580.010), deberá presentarse un informe al MHSOAC antes del 31 de diciembre siguiente a la conclusión del primer ejercicio fiscal de ejecución del proyecto. Aunque la ejecución de este proyecto se ha retrasado, este informe se ha elaborado para proporcionar al MHSOAC y a las partes interesadas del condado de Monterey una actualización del estado de este proyecto de Innovación. De conformidad con el Título 9 del Código Normativo de California (9 CCR § 3580.010), el contenido de este Primer Informe Anual de Innovación incluirá actualizaciones sobre lo siguiente:

- Si se han introducido cambios en el Proyecto de Innovación durante el periodo cubierto por el informe y cuáles han sido, así como los motivos de dichos cambios.
- Datos de evaluación disponibles, incluidos los resultados del Proyecto de Innovación e información sobre qué elementos del Proyecto están contribuyendo a los resultados.
- Información sobre el programa recopilada durante el periodo del informe, incluido el número de participantes y los datos demográficos de los participantes atendidos.
- Cualquier otro dato que el Condado considere pertinente.

Resumen del proyecto

El proyecto RCFI pretende fomentar la colaboración interinstitucional y comunitaria en materia de servicios y ayudas de salud mental modificando una práctica existente en este campo. En concreto, el proyecto RCFI aumentará la disponibilidad de centros de atención residencial para adultos con enfermedades mentales graves (serious mental illness, SMI) en el condado de Monterey y apoyará a estos centros para que sean cultural y lingüísticamente receptivos. Para ello, MCBH buscará a los operadores de las instalaciones existentes e involucrará a nuevos propietarios que estén interesados en proporcionar servicios más receptivos cultural y lingüísticamente. A lo largo de dos fases, el proyecto desarrollará e impartirá la formación y el apoyo necesarios para que los propietarios puedan ejecutar y mantener con éxito tales servicios.

El problema

El proyecto RCFI se desarrolló en respuesta a los comentarios de la comunidad y de los consumidores que citaban la necesidad de (a) una programación que abarque las culturas y experiencias de las personas, (b) un acceso ampliado y una atención de calidad en las comunidades locales, especialmente para los adultos sin hogar con SMI, y (c) un cambio a nivel de sistemas para abordar la crisis de la vivienda. Además de esta respuesta de los miembros de la comunidad, un examen interno de los recursos locales puso de manifiesto la insuficiencia de camas para adultos con SMI y la falta de servicios de atención residencial cultural y lingüísticamente receptivos.

En los últimos años, se han cerrado al menos tres centros de atención residencial en el condado de Monterey, lo que ha supuesto una pérdida de más de 50 camas para adultos con SMI. Cuando las personas con SMI son dadas de alta de niveles superiores de atención pero no disponen de una vivienda adecuada, a menudo esto conduce a otra crisis de salud mental y a un retorno a la atención de alto nivel, a la institucionalización o a la falta de vivienda. Entre los obstáculos más comunes a la apertura y el mantenimiento de centros residenciales para adultos se encuentran la falta de financiación, la falta de aceptación por parte de la comunidad y los problemas de personal.

Además, una revisión interna de los centros de atención residencial para adultos con SMI en el condado de Monterey determinó que estos programas no estaban diseñados para responder a las necesidades culturales y lingüísticas de sus residentes. Por ejemplo, aunque los latinos representan el 78% de los beneficiarios de Medi-Cal, ningún centro de atención residencial ofrece servicios que abarquen las tradiciones culturales latinas comunes. Los gerentes de MCBH estiman que 150 consumidores adicionales del Sistema de Cuidado de Adultos se beneficiarían de instalaciones de cuidado residencial cultural y lingüísticamente receptivas.

Para abordar estas cuestiones, algunos condados han puesto en marcha programas que ayudan a los consumidores en la transición a un nivel inferior de atención o han abordado directamente el problema de la vinculación de los consumidores a una vivienda adecuada. Sin embargo, no parece que ningún programa de California haya puesto en marcha centros de atención residencial cultural y lingüísticamente relevantes para adultos con SMI, y no hay información fácilmente disponible sobre cómo hacerlo.

La solución

Para aumentar la disponibilidad de centros de atención residencial cultural y lingüísticamente receptivos para adultos con SMI, el proyecto RCFI reconvertirá propiedades residenciales y comerciales para dar apoyo a los clientes de atención residencial y rejuvenecer los centros existentes que tienen dificultades para funcionar. El proyecto consta de dos fases:

> *Fase I: Investigación y planificación* - Identificar y desarrollar la formación y los apoyos necesarios para equipar a los propietarios para que gestionen centros de atención

residencial que respondan cultural y lingüísticamente a las necesidades de la población local con SMI.

Fase II: Puesta en práctica - Educar a los propietarios sobre cómo integrar en sus instalaciones servicios más sensibles desde el punto de vista cultural y lingüístico. Proporcionar a los propietarios formación y asistencia técnica relacionadas con el funcionamiento de una pequeña empresa.

Objetivos de aprendizaje

El proyecto RCFI tiene como objetivo establecer opciones de vivienda cultural y lingüísticamente sensibles para adultos con SMI en el condado de Monterey. La financiación actual es para la Fase I del proyecto; la Fase I se centra en investigar (a) los retos a los que se enfrentan los operadores de centros de atención residencial, y (b) los retos a los que se enfrentan los individuos de grupos culturales particulares que sufren SMI. Los resultados de esta fase servirán de base a los materiales y la infraestructura para formar y apoyar a los propietarios en la gestión de instalaciones cultural y lingüísticamente receptivas (en la fase II). A continuación se describen los objetivos de aprendizaje de la Fase I.

1. Describir los atributos y las necesidades específicas de los centros de atención residencial cultural y lingüísticamente receptivos que atienden a la población con SMI.

2. Determinar los obstáculos que impiden el desarrollo y la sostenibilidad de los centros de atención residencial.

3. Determinar los apoyos necesarios para ayudar a los propietarios que ya están integrados en la comunidad y están interesados en convertir su propiedad en un centro de atención residencial.

4. Esbozar el apoyo necesario para garantizar que las residencias de ancianos sean financieramente sostenibles para los propietarios.

5. Determinar qué materiales y asistencia técnica serán necesarios para apoyar la aplicación en la Fase II.

Recursos

El plan del proyecto del IFRC indica que se utilizará el siguiente personal para ejecutar la Fase I del proyecto:

Puesto	Responsabilidades
Analista de gestión II	Desempeñar la función de Coordinador de Innovación para proporcionar/apoyar la gestión de proyectos, la coordinación de servicios, las comunicaciones y la divulgación, la adquisición de proveedores, la evaluación y las actividades de elaboración de informes.
Epidemiólogo de Salud Pública I	Participar y colaborar con los proveedores y las partes interesadas en la Fase I para desarrollar un plan de evaluación para la aplicación de la Fase II.
Gestor de Servicios de Salud Conductual II	Supervisar y aprobar las entregas de los proveedores y prestar asistencia técnica en materia de coordinación de servicios y otros asuntos, según sea necesario.
Auxiliar de salud mental	Funcionan como especialistas inter pares para garantizar que las actividades de la Fase I y la Fase II sean culturalmente competentes y estén orientadas al consumidor.
Consultor(es)	Proporcionar conocimientos especializados en certificación y gestión de centros de atención residencial, servicios de vivienda de apoyo, competencia cultural y lingüística, marketing y comunicaciones. Investigar y diseñar un plan de ejecución de la Fase II convincente y factible.

Cronología

El calendario completo de este proyecto no superará los cinco años, tal como exige el Título 9 del Código Normativo de California (9 CCR § 3910.010). La Fase I se desarrollará a lo largo de 2 años:

- *3-6 meses*: Contratar a los consultores y/o proveedores necesarios mediante un proceso de solicitud de propuestas (Request for Proposal, RFP).

- *12-18 meses*: Los consultores y/o proveedores evaluarán las oportunidades y barreras para la implementación y crearán un plan de implementación procesable (es decir, un plan de Fase II) para la incubación de instalaciones de atención residencial cultural y lingüísticamente receptivas para mitigar los problemas de inestabilidad de la vivienda entre la población con SMI e impactar positivamente en los resultados de salud mental. Las actividades a realizar generalmente incluirán:

    - Identificar las necesidades culturales/lingüísticas de la población de interés e identificar/informar las herramientas y la formación correspondientes para que los proveedores de centros de atención residencial respondan adecuadamente a las necesidades culturales/lingüísticas de la población de interés que puedan mejorar la retención y los resultados

- Investigar los retos conocidos y actualmente desconocidos que experimentan los operadores de centros de atención residencial en el condado de Monterey y California y que repercuten negativamente en su sostenibilidad, e identificar soluciones a través de la asistencia técnica, la formación y/o el cambio de políticas

- Identificación y captación de propietarios interesados

- Planificación con MCBH para establecer una estrategia para proporcionar la colocación de los clientes y la coordinación de la atención

Presupuesto

La Fase I del proyecto del IFRC cuenta con un presupuesto total aprobado de $792,130, distribuidos del siguiente modo:

Categoría presupuestaria	**Año 1**	**Año 2**	***Total***
Salarios del personal	$193,078	$193,078	*$386,155*
Costos directos	$171,921	$171,921	*$343,842*
Costos indirectos	$31,066	$31,066	*$62,133*
Total	***$396,065***	***$696,065***	***$792,130***

Actualizaciones y cambios de proyectos en el año fiscal 2021/22

El proyecto RCFI aún no ha comenzado a ejecutarse. La publicación de la Solicitud de Propuesta (RFP) para adquirir los proveedores necesarios para este proyecto se retrasó debido a la capacidad limitada de personal dentro de MCBH y el Departamento de Compras de Contratos del Condado de Monterey. En el año fiscal 2021/22 no se llevaron a cabo actividades, por lo que no se dispone de actualizaciones específicas sobre la ejecución del proyecto. La solicitud de propuestas se publicará en el año fiscal 2022/23.

Datos de evaluación

No se contrató a ninguna persona para este proyecto y no se realizaron actividades durante el año fiscal 2021/22. Por lo tanto, no se dispone de datos de evaluación para este periodo.

Los futuros datos de evaluación podrán examinar:

- Necesidades específicas de las personas con SMI en el condado de Monterey.
- La eficacia del modelo propuesto de centros de atención residencial cultural y lingüísticamente receptivos.
- El número y las características de los propietarios interesados en participar en el proyecto, y sus necesidades identificadas.
- Experiencia y satisfacción de los consumidores en relación con la receptividad cultural y lingüística de las instalaciones.
- Mejora de los consumidores identificada por el número de días sin hogar, las tasas de encarcelamiento, las visitas a urgencias, el tratamiento de los síntomas, el consumo de sustancias, el interés por la educación y otros indicadores.

Appendix A – Approval Letter

[approval letter will be in the pdf file]

MONTEREY COUNTY BEHAVIORAL HEALTH

Avanzando Juntos Forward Together

TRANSPORTATION COACHING PROGRAM
FINAL INNOVATIONS REPORT FY2018-2022

Prepared by:

EVALCORP

Measuring What Matters℠

Acknowledgments

Monterey County thanks the Interim Inc staff and clinical staff working in the MCBH Adult System of Care. These staff worked collaboratively to coordinate case management and mental health services in support of this project. The County also like to thank MHSOAC for support and approval of funds to deliver this project. Finally, Monterey County thanks the EVALCORP team for preparing this report.

Contents

Introduction

The Mental Health Services Oversight and Accountability Commissions (MHSOAC) approved use of Mental Health Services Act Innovation Component funding for Monterey County Behavioral Health (MCBH) to implement the "Transportation Coaching Project" (TCP), under the original title "Transportation Coaching by Wellness Navigators", on August 23, 2018. As required by Title 9 California Code of Regulations – Division 1, Chapter 14, Article 5, Section 3580, MCBH must submit Innovation Project Reports on an annual basis for the duration of the Innovation Plan. These regulations state the first Annual Innovation Project Report must be submitted prior to the December 31st following the first fiscal year of implementation, whereas all subsequent Innovation Project Reports shall by submitted as part of the Mental Health Services Act (MHSA) Three-Year Program and Expenditure Plan or Annual Update, except for the final report, which is submitted within 6 months of the project's completion. The Innovation Project Report presented in this document is the fourth and final Innovation Project Report for the TCP, pertaining to activities taken plan in FY2018/22, and is submitted as part of the MCBH MHSA FY2022/23 Annual Update. The purpose of this Innovation Project Report is to update MCBH stakeholders and the MHSOAC on the implementation status of the Innovation Project Plan. Specifically, as required by the aforementioned regulations, contents of this Annual Innovation Report shall include updates on:

- Whether and what changes were made to the Innovation Project during the reporting period and the reasons for changes.
- Available evaluation data, including outcomes of the Innovation Project and information about which elements of the Project are contributing to outcomes.
- Program information collected during the reporting period, including number of participants and demographics of participants served.
- Any other data the County considers relevant.

Project Overview

The TCP aims to increase access to mental health services by introducing a new practice into the mental health system. This practice includes the development and use of a Transportation Needs Assessment Tool (TNAT) to inform and guide the transportation coaching activities of peer support staff Wellness Navigators (WN's). The intended result of the coaching activities prescribed by TNAT results is to promote greater independence and capability of clients to participate in both clinical and non-clinical activities that support their wellness and recovery.

<u>The Problem</u>

The TCP was developed in response to consistent community and consumer feedback citing transportation challenges as a major barrier to receiving the mental healthcare they or their loved ones need. Some of the cited transportation challenges include a consumers' inability to obtain a license and/or vehicle, drive, receive timely transportation via family and friends, and afford and/or navigate the public transit system. MCBH has previously responded to meet some of these challenges by allowing staff to provide transportation services. However, demand for transportation services continually exceeded the capacity MCBH. The negative consequences of this strained system are two-fold. First, transportation needs of existing and potential consumers of mental health services going unmet means clients are experiencing prolonged suffering and recovery. Second, to alleviate these transportation barriers and promote access to services, qualified mental health professionals are now spending an inordinate amount of time providing transportation services instead of providing more meaningful therapeutic services.

The Solution

To support and promote the independent transportation skills of mental healthcare consumers, the TCP introduced the TNAT to standardize a review of transportation-related barriers and client goals. TNAT results are used to prescribe targeted WN coaching activities. The intended result of the project is to support client independence as part of their wellness and recovery plan, as well as aid in the efficient use of clinical resources.

The TCP plan identified 5 phases by which the project will be carried out:

1. Develop the transportation needs assessment tool

2. Hire and train Wellness Navigators

3. Enroll consumers in the program

4. Implement transportation coaching activities

5. Evaluate program impacts Learning Goals

This Innovation project aims to increase the independent transportation skills of MCBH clients by employing a transportation coaching program that is informed by a new TNAT. The TNAT is comprised of nine items, of which the first three are ordinal, the following four are checklists, and the final two are dichotomous yes/no queries. The participant's Avatar number (a patient ID number) is used to connect TNAT results to other participant information such as demographics. Each TNAT is dated. The TNAT contains several open-ended "Other" selections on checklist to allow participants to describe responses not originally envisioned by the designers of the instrument.

While the service goals in the project are to increase access to services and improve rates of recovery, the primary Innovation learning goals of this project are focused on measuring the impact and value of the TNAT. By creating a valuable tool and identifying best practices for

promoting client independence, this Innovation project may offer valuable knowledge to the broader mental health services community. Specifically, the lessons learned through the TCP may aid mental health service agencies in more effectively planning and implementing wellness navigation and transportation coaching services.

Learning Goals

Specific learning goals of this project are to:

1. Assess whether or not the use of the transportation needs assessment tool and subsequent transportation coaching lead to greater levels of independence and recovery reported by participating clients.

2. Identify which transportation coaching activities correspond to improved levels of independence and recovery.

3. Quantify the staffing costs/investment associated with improving a clients' level of independence (i.e. "step-down" in level of transportation coaching needs).

The scores observed on the TNAT are central to evaluating the learning goals of this project. The level of change between pre- and post-intervention TNAT scores indicates the level of improvement a client has experienced, and also aids in identifying coaching activities that may have contributed to that success. Additionally, analysis of staff time allocated towards activities and clients demonstrating success is used to evaluate TCP learning goals.

Resources

The TCP project plan stipulates MCBH to assign partial staff time of an Analyst and Epidemiologist for purposes of project coordination, evaluation, and reporting. Implementation of the TCP is performed by a contracted services provider. Activities include the hiring and management of WN's, administration of the TNAT, WN coaching activities and data collection.

Timeline

The original timeframe (duration) of this Innovation project is 3 years, but project implementation was extended to 4 years (as discussed in the FY 2019/20 INN report). The original timeline for key phases / deliverables is as follows:

- January 2019 – March 2019 (3 months): MCBH will develop Transportation Needs Assessment Tool, and sequence vetting and approval of a final product through the Mental Health Commission, Cultural Relevancy and Humility Committee and Recovery Task Force.
- January 2019 – March 2019 (3 months): Source vendor, negotiate contract terms, and process contract through county purchasing procedures. • April 2019 – June 2019 (3 months): Develop transportation coaching curriculum for Wellness Navigators. Complete trainings before end of calendar year.
- July 2019 – June 2021 (2 years): Begin assessments of new and existing clients in Adult System of Care programs. Continue providing assessment and re-assessments through June 2021. Collect assessment data and provide technical assistance throughout implementation timeline.
- July 2021 – December 2021 (6 months): Conduct evaluation, including evaluation of assessment data and gathering qualitative data from staff and participants

Budget

The TCP has a total approved budget of $1,234,000. This funding was awarded to MCBH by the MHSOAC on August 23, 2018.

Demographics

Table 1. FY 21-22 Demographics

Race	Count	Percentage
Alaskan Native	0	0%
American Indian	0	0%
American Indian/Sout	0	0%
Asian Native	0	0%
Black/African-Americ	3	5%
Cambodian	0	0%
Chinese	0	0%
Filipino	0	0%
Guamanian	0	0%
Hawaiian	0	0%
Hispanic	0	0%

Ethnicity	Count	Percentage
Cuban	0	0%
Mexican/Mexican Amer	13	24%
Not Hispanic	21	38%
Other Hispanic/Latin	13	24%
Puerto Rican	0	0%
Unknown	8	15%
Total	55	

Gender	Count	Percentage
Female	27	49%
Male	28	51%

Japanese	0	0%
Korean	0	0%
Laotian	0	0%
Middle Eastern	0	0%
Samoan	0	0%
Vietnamese	0	0%
Other Asian	2	4%
Other Race	27	49%
White	23	42%
No Entry	0	0%
Total	55	

Transgender	0	0%
Total	55	

Age	Count	Percentage
18-25	0	0%
26-35	10	18%
36-45	11	20%
46-55	13	24%
56-65	13	24%
66-75	7	13%
76+	1	2%
Total	55	

Table 2. FY19-22 Combined Demographics

Race	Count	Percentage
Alaskan Native	0	0%
American Indian	0	0%
American Indian/Sout	0	0%
Asian Native	0	0%
Black/African-Americ	5	7%
Cambodian	0	0%
Chinese	0	0%
Filipino	1	1%
Guamanian	0	0%
Hawaiian	0	0%
Hispanic	18	24%
Japanese	0	0%
Korean	0	0%
Laotian	0	0%
Middle Eastern	0	0%
Samoan	0	0%
Vietnamese	1	1%
Other Asian	2	3%
Other Race	17	23%
White	31	41%
No Entry	0	0%
Total	75	

Ethnicity	Count	Percentage
Cuban	0	0%
Mexican/Mexican Amer	21	28%
Not Hispanic	32	43%
Other Hispanic/Latin	13	17%
Puerto Rican	1	1%
Unknown	8	11%
Total	75	

Gender	Count	Percentage
Male	71	44%
Female	91	56%
Transgender	0	0%
Total	162	

Note: Exact age distributions for FY19-20 and FY20-21 are not available.

Evaluation

To determine the extent to which the goals of the project were met, data from three years of project implementation were made available to Monterey County's contracted evaluation team, EVALCORP. These data included the results of the TNAT (see above for description), participant demographic information captured in Electronic Health Records, and administrative billing data. Learning Goal #1 was assessed using a combination of TNAT results and demographic data, while learning Goal #2 was assessed using TNAT results alone. Learning Goal #3 was assessed using administrative billing data from a later iteration of the Transportation Coaching program implemented using CSS funding. TNAT and demographic data cover FY19-21 since no services were provided by the program in FY18-19. Billing data from FY18-21 were not tracked by the program, limiting the extent to which Learning Goal #3 can be fully addressed. However, since the funding for the Transportation Coaching program was transferred from the INN funding stream to the CSS funding stream in 2022, it was possible to gather data on the current version of the Transportation Coaching program.

Datasets from FY19-21 were merged into a single file and cleaned. Since some participants took part in the program during multiple years, duplicate participants were identified and removed from the dataset. Clients were retained for the first cohort year in which they participated: for example, a client who participated in cohort 2 and 3 would be removed from cohort 3. A total of 14 duplicate entries were removed from the dataset following this procedure.

Learning Goal 1

Assess whether or not the use of the transportation needs assessment tool and subsequent transportation coaching lead to greater levels of independence and recovery reported by participating clients.

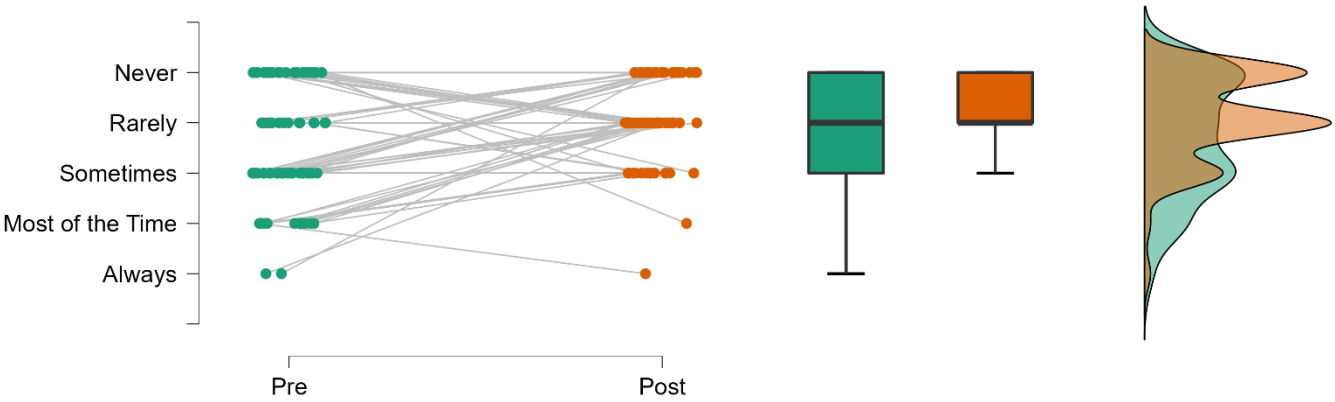
The transportation needs assessment tool (TNAT) and Transportation Coaching session are evaluated in this report as two parts of the same intervention. Independence and recovery were defined as the extent to which clients experienced 1) a decrease in missed appointments and 2) an increase in the frequency with which they were able to get to appointments without the help of others.

The self-reported frequency with which clients missed appointments decreased from pre-intervention to post-intervention. Participation in the program was associated with a change of .43 points on a five-point scale of self-reported frequency of missed appointments, from an average of 3.69 to 4.12 points. In practical terms, this shift is due to the fact that roughly 83% of the participants who indicated that they missed their appointments "Always" or "Most of the Time" on the pre-survey had changed their rating to "Sometimes" "Rarely" or "Never" on the

post-intervention survey. A Bayesian paired samples Wilcoxon signed-rank test[1] was used to test the hypothesis that this change in self-reported frequency of missed appointments was due to an actual shift rather than to chance variation in the sample.[2] The (alternative) hypothesis that the change from pre-intervention to post-intervention was not due to chance variation alone was found to be 18 times more likely than the hypothesis that it was due to mere sampling variation (BF_{10} = 18.479), typically considered "strong evidence." [3] That is, according to our model we can be about 95% certain that this result was not due to chance variation.

Figure 1. Plot of Change in Distribution of Missed Health Appointments

Miss appointments - Miss appointments POST



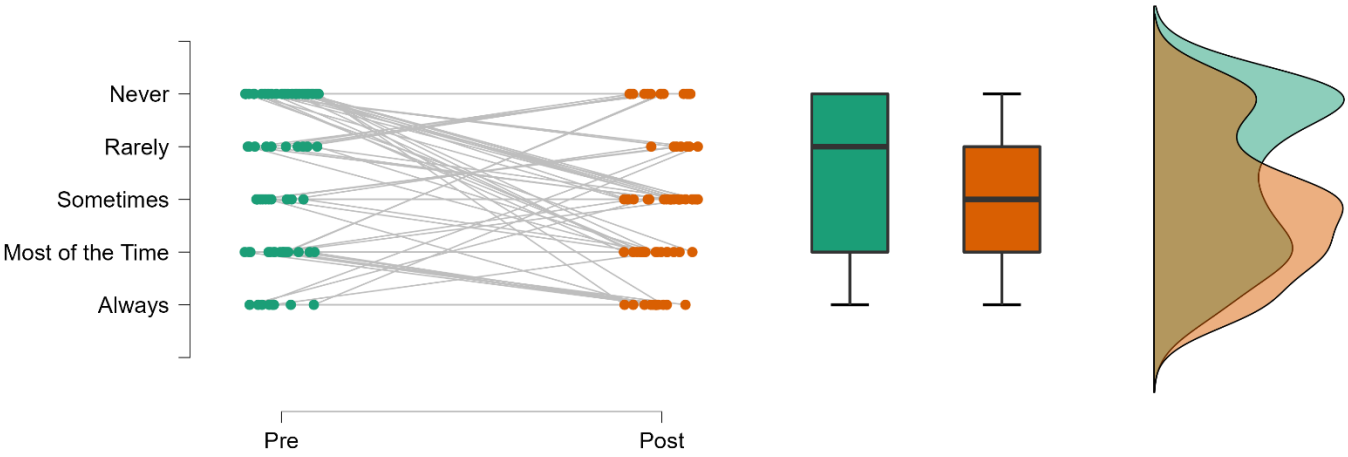
How often do you miss your health appointments due to transportation issues?

Likewise, the self-reported frequency with which clients were able to navigate to appointments on their own increased from pre-intervention to post-intervention time points. Participation in the program was associated with a change of .62 on a five-point scale of frequency of attending appointments on one's own, from an average of 3.49 to 2.87 points. In terms of people, this shift is due to the fact that roughly 46% of the participants who indicated that they attended their appointments solo "Never" or "Rarely" on the pre-survey had changed their rating to "Sometimes" "Most of the Time" or "Always" on the post-intervention survey. Once again, a Bayesian paired samples Wilcoxon signed-rank test was used to determine the likelihood of the hypothesis that this change in self-reported frequency of missed appointments was due to an actual shift rather than to chance variation in the sample. The odds that the change from before to after the intervention were due to a true change rather than chance variation were

[1] See: van Doorn, J., Ly, A., Marsman, M., & Wagenmakers, E. J. (2020). Bayesian rank-based hypothesis testing for the rank sum test, the signed rank test, and Spearman's ρ. *Journal of Applied Statistics*, 47(16), 2984-3006.
[2] A default Cauchy prior with a scale of .707 and centered at 0 was used to express weak prior expectations that the effect size would be near to 0 and non-extreme.

estimated at roughly 42 to 1, typically considered "very strong" evidence (BF_{10} =41.886).[3] In other words, according to our model we can be about 98% sure that this result was not due to chance.

Figure 2. Plot of Change in Distribution of Getting to Health Appointments Solo



How often do you get to your appointment on your own without the help of another person?

Per §3580.020(a5c), the "Final Innovative Project Report shall include… any variation in outcomes based on demographics of participants, if applicable." A test of row by column independence using Bayesian contingency tables revealed that non-white[4] participants were more likely to report that they were able to attend more appointments by themselves at the conclusion of the program. To illustrate, 60% of non-white participants (n=47) moved at least one level towards a greater frequency of solo appointments, while only 25% of white participants moved at least one level (n = 28). Meanwhile, white participants were more likely to experience no change or a decrease in independence during the evaluation period. According to our model, we can be about 97% sure that this pattern is not due to chance, evidence which would typically be considered "strong" (BF_{10}, 28.539).[3] However, using the same type of model, there was no evidence of differences in attending appointments by race.

Table 3. Contingency Table of Change in Solo Appointments by Participant Race

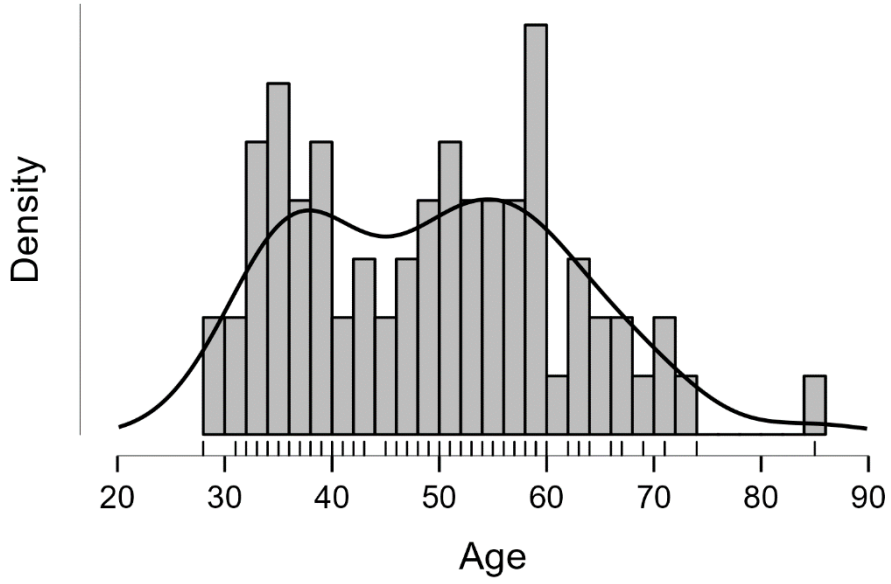
		Change in Solo Appointments			
Race (recoded)		**Declined**	**No Change**	**Improved**	**Total**
Non-white	Count	7.000	12.000	28.000	47.000

[3] Jeffreys, H. (1961). The theory of probability (3rd Edition). New York, NY: Oxford University Press.
[4] In this analysis, race was recoded into White and Non-white categories to ensure adequate sample sizes for hypothesis testing. "White" was defined similarly to the "White alone" category used on the US Census.

	% within row	14.894 %	25.532 %	59.574 %	100.000 %
White	Count	10.000	11.000	7.000	28.000
	% within row	35.714 %	39.286 %	25.000 %	100.000 %
Total	Count	17.000	23.000	35.000	75.000
	% within row	22.667 %	30.667 %	46.667 %	100.000 %

Similarly, a Bayesian test of rows columns independence was used to test whether program outcomes differed by age. Participants were split at the median age, roughly 50 years old. Participants younger than 30 were not well-represented in the sample, meaning that the aforementioned finding concerning age should be treated provisionally. There was no evidence of a difference in age among participants on either of the two key outcomes.

Figure 3. Distribution of Participant Ages in the Sample



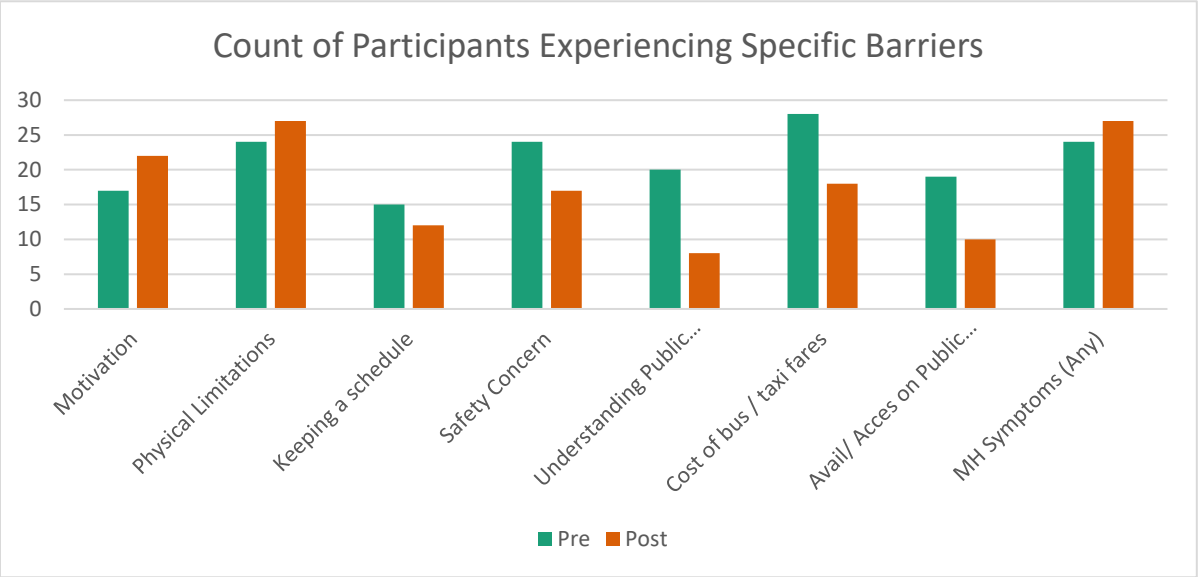
Learning Goal 2

Identify which transportation coaching activities correspond to improved levels of independence and recovery.

To identify activities that correspond to improved levels of independence and recovery, change scores were calculated for each element of the curriculum addressed (i.e. “barriers”) as well as for the outcomes of frequency of missed appointments and solo appointments. Contingency tables were constructed to investigate whether change scores in aspects of the curriculum were associated with change scores in the outcomes of interest. If changes in curriculum scores on

any of the domains tested (e.g. creating a schedule) were associated with changes in outcomes, this difference would be notable as a dependency between the categorical variables. A Bayesian test of row-column independence with a Poisson sampling scheme and default priors[5] was used to test the (alternative) hypothesis that there was a relationship between change in any curricular "barriers" and changes in outcome variables. Eight tests were run for each outcome variable for a total of 16 tests. In no test was evidence for the alternative hypothesis found – all results either provided evidence for the null hypothesis or suggested that not enough information was available to make a determination about the likelihood of the hypotheses. Thus, at the present time, while we are able to detect a change in outcomes of interest - missing appointments and attending appointments solo - these changes were not found to be associated with changes in constructs targeted by the curriculum. This finding suggests that the mechanism by which program outcomes are reached is unknown or that current measures are insufficiently sensitive to changes.

Figure 4. Barriers Experienced by Participants at Pre and Post Intervention



The overall average number of barriers experienced by participants did not significantly change from pre-intervention to post-intervention. As Figure 4 illustrates, this was the result of a redistribution of barriers from the items shown on the right-hand side to the left-hand side of the graphic. For instance, while participants were less likely to indicate that understanding public transit was a barrier on the post-survey than on the pre-survey, they were more likely to indicate that motivation was a barrier instead. This reallocation of barriers resembles the effect of squeezing a balloon – compressing one side of the balloon seems only to have inflated its other side.

[5] Jamil, T., Ly, A., Morey, R. D., Love, J., Marsman, M., & Wagenmakers, E. J. (2017). Default "Gunel and Dickey" Bayes factors for contingency tables. *Behavior Research Methods*, *49*(2), 638-652.

Learning Goal 3

Quantify the staffing costs/investment associated with improving a clients' level of independence (i.e. "step-down" in level of transportation coaching needs).

Data from a 2022 version of the Transportation Coaching program were used to calculate the average cost per participant. In the time period studied, July to November 2022 (133 days) staff spent a total of 23.9 hours on Transportation Coaching. On average, staff spent 5.39 hours conducting coaching activities in each 30 day period. Per client, the amount of time spent on coaching activities ranged from 12 minutes to more than 8 hours, with an average of 1.99 hours per client.

"Wellness Navigators" are the staff tasked with conducting Transportation Coaching activities. Salary information about the Wellness Navigators shows that the salary range for this position is $19.43-26.07 per hour. Taking a midpoint between the top and bottom of this salary range ($22.75) we can calculate the average cost per client of transportation coaching - $45.31. However, because both salaries and time per participant vary, this potential expense ranged from $19.63 to $219.77 per client during the evaluation period. Given the 5.39 hours per 30-day period average, an organization can expect to spend between $104.75 and $140.54 per month on Transportation Coaching.

By taking the average cost per client ($45.31) and the average step down in transportation needs of clients, it is possible to estimate the cost-effectiveness of the program. While several indicators are available from the TNAT to estimate the effect of the program, the frequency of missed appointments was chosen to summarize these effects. One reason to focus specifically on missed appointments is the high cost of a missed appointment, which one popular study placed at $200 in 2017 ($243 in 2022 dollars).[6]

Our study of the Transportation Coaching program revealed that participation in the program was associated with a change of .44 points on a five-point scale of self-reported frequency of missed appointments, from an average of 3.74 to 4.17 points. In practical terms, this shift is due to the fact that roughly 83% of the participants who indicated that they missed their appointments "Always" or "Most of the Time" on the pre-survey had changed their rating to "Sometimes" "Rarely" or "Never" on the post-intervention survey. The hypothesis that this change from pre-intervention to post-intervention was not due to chance variation alone was found to be 18 times more likely than the hypothesis that it was due to chance variation alone (BF_{10} =18.479). In the original design of the evaluation of the Transportation Program, program administrators planned to collect the actual number of missed appointments per client. However, due to an error, these data were not collected. As a result, the extent of cost savings

[6] Gier, J. (2017). Missed appointments cost the US healthcare system $150 B each year. *Health Management Technology*, 2.

from the program can only be estimated via the proxy measure of self-reported appointment-going behavior.

Taking into account the above information, the average cost of shifting participant behavior towards missing fewer appointments is roughly $45. Compared to the oft-cited estimate of more than $200 in costs associated with missed appointments, a Transportation Coaching session that prevents even a single missed appointment would yield a favorable return on investment.

Conclusions and Recommendations

Clients who participated in Transportation Coaching using the TNAT were less likely to have missed appointments and were more likely to attend appointments on their own. However, it was not possible to determine with any certainty which aspects of the Transportation Coaching curriculum led to this change. The average cost of shifting participant behavior towards fewer missing appointments is estimated at roughly $45, given average changes in self-reported participant behavior and average costs per participant.

Per §3580.020(a5c), the "Final Innovative Project Report shall include… any variation in outcomes based on demographics of participants, if applicable." Our analysis suggests that non-white participants were more likely to benefit from the Transportation Program in the strict sense of being more likely to attend appointments alone after training. However, without further information to elucidate the potential cause of this difference, this result should be considered with caution. The program also appears to have had positive impacts on white and non-white participants insofar as both groups were less likely to report missing appointments. Program benefits appear to be distributed evenly to members of different age cohorts, although younger participants were not well represented in the sample.

The TNAT was effective in showing self-reported change in missed appointments and appointments attended on one's own. Additionally, the TNAT appears to have served as a useful guide for Wellness Navigators. However, revisions to the TNAT and the scoring method are recommended. Currently the TNAT score combines elements from distinct participant needs and behaviors into a single composite score. From a practical perspective, this summing method is likely not needed to determine participant needs. Instead, a qualitative examination of item responses by Wellness Navigators is recommended to guide future Transportation Coaching.

Appendix A – TNAT

Transportation Needs Assessment Survey

MHSA Innovations Project

Avatar#:_____ ***Date:***_____

1. How often do you miss your health appointments due to transportation issues?
☐ Always ☐ Most of the time ☐ Sometimes ☐ Rarely ☐ Never

2. How often do you get to your appointment on your own, without the help of another person?
☐ Always ☐ Most of the time ☐ Sometimes ☐ Rarely ☐ Never

3. How often do you go out for other activities that support your wellness and recovery?
☐ Always ☐ Most of the time ☐ Sometimes ☐ Rarely ☐ Never

3a. Which types of activities would you like to do/attend on your own? *(select all that apply)*
- ☐ Errands/Shopping (grocery store, bank, etc.)
- ☐ Religious
- ☐ School
- ☐ Work/Volunteering
- ☐ Sports/Leisure Activities
- ☐ Social Outings
- ☐ Other (Please specify:_____)

4. How do you currently get around?
(select all that apply)
- ☐ Walk
- ☐ Bike
- ☐ Drive myself
- ☐ Driven by friend/family
- ☐ Driven by mental healthcare worker
- ☐ MST
- ☐ MST Rides
- ☐ CCAH (Medi-Cal Transportation Benefit)
- ☐ Taxi
- ☐ Rideshare app (Uber, Lyft)
- ☐ Other (Please specify:_____)

5. How would you like to get around?
(select all that apply)
- ☐ Walk
- ☐ Bike
- ☐ Drive myself
- ☐ Driven by friend/family
- ☐ Driven by mental healthcare worker
- ☐ MST
- ☐ MST Rides
- ☐ CCAH (Medi-Cal Transportation Benefit)
- ☐ Taxi
- ☐ Rideshare app (Uber, Lyft)
- ☐ Other (Please specify:_____)

6. What prevents you from traveling, or makes travel difficult for you?
(select all that apply)
- ☐ Motivation to get out of the house
- ☐ Physical Limitations
- ☐ Keeping a schedule for myself
- ☐ Safety concerns (Please specify:_____)
- ☐ Understanding public transit system (schedules, routes)
- ☐ Cost of bus and/or taxi fares
- ☐ Availability/Accessibility of public transportation
- ☐ Mental health symptoms (Please specify: _____)
- ☐ Other (Please specify:_____)

7. Are you aware of low or no-cost rideshare programs? ☐ Yes ☐ No
(If yes, please specify:_____)

8. Are you interested in using low- or no-cost rideshare programs? ☐ Yes ☐ No

MONTEREY COUNTY
BEHAVIORAL HEALTH

Avanzando Juntos Forward Together

PROGRAMA DE ENTRENAMIENTO DE TRANSPORTE
INFORME FINAL DE INNOVACIONES PARA EL AÑO FISCAL 2018-2022

Preparado por:

EVALCORP
Measuring What Matters℠

Reconocimientos

El condado de Monterey agradece al personal de Interim Inc y al personal clínico que trabajan en el Sistema de Atención para Adultos del MCBH. Este personal trabajó en colaboración para coordinar la gestión de casos y los servicios de salud mental en apoyo de este proyecto. El condado también desea agradecer al MHSOAC por el apoyo y la aprobación de los fondos para llevar a cabo este proyecto. Finalmente, el condado de Monterey agradece al equipo de EVALCORP por preparar este informe.

Contenido

Introducción

Las Comisiones de Supervisión y Responsabilidad de los Servicios de Salud Mental (Mental Health Services Oversight and Accountability Commissions, MHSOAC) aprobaron el uso de los fondos del componente de innovación de la Ley de Servicios de Salud Mental para la Salud conductual del condado de Monterrey (Monterey County Behavioral Health, MCBH) para implementar el "Proyecto de asesoramiento en transporte" (Transportation Coaching Project, TCP), con el título original "Asesoramiento de transporte por parte de navegantes de bienestar", el 23 de agosto de 2018. Según lo exige el Título 9 del Código de Regulaciones de California (División 1, Capítulo 14, Artículo 5, Sección 3580), el MCBH debe presentar informes de proyectos de innovación anualmente durante la vigencia del Plan de Innovación. Estas regulaciones establecen que el primer informe anual del proyecto de innovación debe presentarse antes del 31 de diciembre siguiente al primer año fiscal de implementación, mientras que todos los informes posteriores del proyecto de innovación deberán presentarse como parte del programa trienal y el plan de gastos o actualización anual de la Ley de Servicios de Salud Mental (Mental Health Services Act, MHSA), excepto el informe final, que se presenta dentro de los 6 meses posteriores a la finalización del proyecto. El informe del proyecto de innovación que se presenta en este documento es el cuarto y último informe del proyecto de innovación para el TCP, relativo a las actividades planificadas en el año fiscal 2018/22, y se presenta como parte de la actualización anual del MCBH MHSA para el año fiscal 2022/23. El propósito de este informe del proyecto de innovación es actualizar a las partes interesadas del MCBH y al MHSOAC sobre el estado de implementación del Plan del Proyecto de Innovación. Específicamente, tal como lo exigen los reglamentos antes mencionados, el contenido de este Informe anual de innovación incluirá actualizaciones sobre:

- Si se han introducido cambios en el Proyecto de Innovación durante el periodo cubierto por el informe y cuáles han sido, así como los motivos de dichos cambios.
- Datos de evaluación disponibles, incluidos los resultados del Proyecto de Innovación e información sobre qué elementos del Proyecto están contribuyendo a los resultados.
- Información del programa recopilada durante el período del informe, incluida la cantidad de participantes y los datos demográficos de los participantes atendidos.
- Cualquier otro dato que el Condado considere pertinente.

Resumen del proyecto

El TCP tiene como objetivo aumentar el acceso a los servicios de salud mental mediante la introducción de una nueva práctica en el sistema de salud mental. Esta práctica incluye el desarrollo y el uso de una herramienta de evaluación de las necesidades de transporte (Transportation Needs Assessment Tool, TNAT) para informar y guiar las actividades de

asesoramiento en transporte del personal de apoyo entre pares Wellness Navigators (WN). El resultado previsto de las actividades de asesoramiento prescritas por los resultados de TNAT es promover una mayor independencia y capacidad de los clientes para participar en actividades clínicas y no clínicas que apoyen su bienestar y recuperación.

El problema

El TCP se desarrolló en respuesta a los comentarios constantes de la comunidad y los consumidores, que citaban los desafíos del transporte como un obstáculo importante para recibir la atención mental que ellos o sus seres queridos necesitan. Algunos de los desafíos de transporte citados incluyen la incapacidad de los consumidores de obtener una licencia o un vehículo, conducir, recibir transporte oportuno a través de familiares y amigos y pagar y/o navegar por el sistema de transporte público. MCBH ha respondido anteriormente para hacer frente a algunos de estos desafíos al permitir que el personal brinde servicios de transporte. Sin embargo, la demanda de servicios de transporte superó continuamente la capacidad del MCBH. Las consecuencias negativas de este sistema tenso son dobles. En primer lugar, las necesidades de transporte de los consumidores actuales y potenciales de servicios de salud mental que no se satisfacen significan que los clientes experimentan un sufrimiento y una recuperación prolongados. En segundo lugar, para aliviar estas barreras de transporte y promover el acceso a los servicios, los profesionales de la salud mental calificados ahora dedican una cantidad excesiva de tiempo a brindar servicios de transporte en lugar de brindar servicios terapéuticos más significativos.

La solución

Para apoyar y promover las habilidades de transporte independientes de los consumidores de servicios de salud mental, el TCP introdujo el TNAT para estandarizar una revisión de las barreras relacionadas con el transporte y los objetivos de los clientes. Los resultados del TNAT se utilizan para prescribir actividades específicas de entrenamiento de WN. El resultado previsto del proyecto es apoyar la independencia del cliente como parte de su plan de bienestar y recuperación, así como ayudar al uso eficiente de los recursos clínicos.

El plan TCP identificó 5 fases mediante las cuales se llevará a cabo el proyecto:

1. Desarrollar la herramienta de evaluación de necesidades de transporte

2. Contratar y entrenar a Wellness Navigators

3. Inscribir a los consumidores en el programa

4. Implementar actividades de asesoramiento sobre transporte

5. Evaluar los impactos del programa y las metas de aprendizaje

Este proyecto de innovación tiene como objetivo aumentar las habilidades de transporte independientes de los clientes de MCBH mediante el empleo de un programa de asesoramiento

en transporte basado en un nuevo TNAT. El TNAT se compone de nueve elementos, de los cuales los tres primeros son ordinales, los cuatro siguientes son listas de verificación y los dos últimos son consultas dicotómicas de sí/no. El número de avatar del participante (un número de identificación de paciente) se utiliza para conectar los resultados del TNAT con otra información del participante, como la demografía. Cada TNAT está fechado. El TNAT contiene varias selecciones abiertas de "Otros" en la lista de verificación para permitir a los participantes describir respuestas que los diseñadores del instrumento no habían previsto originalmente.

Si bien los objetivos de servicio del proyecto son aumentar el acceso a los servicios y mejorar las tasas de recuperación, los principales objetivos de aprendizaje sobre innovación de este proyecto se centran en medir el impacto y el valor del TNAT. Al crear una herramienta valiosa e identificar las mejores prácticas para promover la independencia del cliente, este proyecto de innovación puede ofrecer conocimientos valiosos a la comunidad de servicios de salud mental en general. Específicamente, las lecciones aprendidas a través del TCP pueden ayudar a las agencias de servicios de salud mental a planificar e implementar de manera más eficaz los servicios de asesoramiento sobre navegación y transporte para el bienestar.

Objetivos de aprendizaje

Los objetivos de aprendizaje específicos de este proyecto son:

1. Evaluar si el uso de la herramienta de evaluación de las necesidades de transporte y la posterior orientación sobre transporte conducen o no a mayores niveles de independencia y recuperación informados por los clientes participantes.

2. Identificar qué actividades de asesoramiento de transporte corresponden a mejores niveles de independencia y recuperación.

3. Cuantificar los costos de personal y la inversión asociados con la mejora del nivel de independencia de los clientes (es decir, "reducir" el nivel de necesidades de asesoramiento en transporte).

Los puntajes observados en el TNAT son fundamentales para evaluar los objetivos de aprendizaje de este proyecto. El nivel de cambio entre las puntuaciones del TNAT previas y posteriores a la intervención indica el nivel de mejora que ha experimentado un cliente y también ayuda a identificar las actividades de entrenamiento que pueden haber contribuido a ese éxito. Además, se utiliza el análisis del tiempo del personal asignado a las actividades y de los clientes que demuestran éxito para evaluar los objetivos de aprendizaje de TCP.

Recursos

El plan del proyecto TCP estipula que el MCBH asignará tiempo parcial al personal de un analista y un epidemiólogo con fines de coordinación, evaluación e informes del proyecto. La implementación del TCP la realiza un proveedor de servicios contratado. Las actividades incluyen la contratación y la gestión de los WN, la administración del TNAT, las actividades de entrenamiento de la WN y la recopilación de datos.

Cronología

El plazo original (duración) de este proyecto de innovación era de 3 años, pero la implementación del proyecto se amplió a 4 años (como se indica en el informe INN del año fiscal 2019/20). El cronograma original para las fases y los resultados clave es el siguiente:

- De enero de 2019 a marzo de 2019 (3 meses): El MCBH desarrollará una herramienta de evaluación de las necesidades de transporte y secuenciará la investigación y aprobación del producto final a través de la Comisión de Salud Mental, el Comité de Relevancia Cultural y Humildad y el Grupo de Trabajo sobre Recuperación.
- De enero de 2019 a marzo de 2019 (3 meses): Buscar un proveedor, negociar los términos del contrato y procesar el contrato mediante los procedimientos de compra del condado.
- De abril de 2019 a junio de 2019 (3 meses): Desarrollar un plan de estudios de entrenamiento de transporte para Wellness Navigators. Completar las capacitaciones antes de que finalice el año calendario.
- De julio de 2019 a junio de 2021 (2 años): Comenzar a evaluar a los clientes nuevos y existentes en los programas del Sistema de Atención para Adultos. Continuar proporcionando evaluaciones y reevaluaciones hasta junio de 2021. Recopilar datos de evaluación y brindar asistencia técnica durante todo el cronograma de implementación.
- De julio de 2021 a diciembre de 2021 (6 meses): Realizar una evaluación, incluida la evaluación de los datos de evaluación y la recopilación de datos cualitativos del personal y los participantes.

Presupuesto

El TCP tiene un presupuesto total aprobado de $1,234,000. Este financiamiento fue otorgado a MCBH por el MHSOAC el 23 de agosto de 2018.

Demografía

Tabla 1. Datos demográficos del año fiscal 21-22

Raza	Conteo	Porcentaje
Nativo de Alaska	0	0%
Indio americano	0	0%
Indio americano/Sur	0	0%
Nativo asiático	0	0%
Negro/Afroamericano	3	5%
Camboyano	0	0%
Chino	0	0%
Filipino	0	0%
Guameño	0	0%
Hawaiano	0	0%
Hispano	0	0%
Japonés	0	0%
Coreano	0	0%
Laosiano	0	0%
Medio Oriente	0	0%
Samoano	0	0%
Vietnamita	0	0%
Otro asiático	2	4%
Otra raza	27	49%
Blanco	23	42%
Sin información	0	0%
Total	55	

Etnicidad	Conteo	Porcentaje
Cubano	0	0%
Mexicano/Mexicano americano	13	24%
No hispano	21	38%
Otro hispano/latino	13	24%
Puertorriqueño	0	0%
Desconocido	8	15%
Total	55	

Género	Conteo	Porcentaje
Femenino	27	49%
Masculino	28	51%
Transgénero	0	0%
Total	55	

Edad	Conteo	Porcentaje
18-25	0	0%
26-35	10	18%
36-45	11	20%
46-55	13	24%
56-65	13	24%
66-75	7	13%
76+	1	2%
Total	55	

Tabla 2. Datos demográficos combinados del año fiscal 19-22

Raza	Conteo	Porcentaje
Nativo de Alaska	0	0%
Indio americano	0	0%
Indio americano/Sur	0	0%
Nativo asiático	0	0%
Negro/Afroamericano	5	7%
Camboyano	0	0%
Chino	0	0%
Filipino	1	1%
Guameño	0	0%
Hawaiano	0	0%
Hispano	18	24%
Japonés	0	0%
Coreano	0	0%
Laosiano	0	0%
Medio Oriente	0	0%
Samoano	0	0%
Vietnamita	1	1%
Otro asiático	2	3%
Otra raza	17	23%
Blanco	31	41%
Sin información	0	0%
Total	75	

Etnicidad	Conteo	Porcentaje
Cubano	0	0%
Mexicano/Mexicano americano	21	28%
No hispano	32	43%
Otro hispano/latino	13	17%
Puertorriqueño	1	1%
Desconocido	8	11%
Total	75	

Género	Conteo	Porcentaje
Masculino	71	44%
Femenino	91	56%
Transgénero	0	0%
Total	162	

Nota: Las distribuciones por edad exactas para los años fiscales 19-20 y 20-21 no están disponibles.

Evaluación

Para determinar en qué medida se cumplieron las metas del proyecto, se pusieron a disposición del equipo de evaluación contratado del condado de Monterey, EVALCORP, los datos de tres años de implementación del proyecto. Estos datos incluyeron los resultados del TNAT (consulte la descripción anterior), la información demográfica de los participantes capturada en los registros médicos electrónicos y los datos de facturación administrativa. El objetivo de aprendizaje #1 se evaluó mediante una combinación de los resultados del TNAT y los datos demográficos, mientras que el objetivo de aprendizaje #2 se evaluó utilizando únicamente los resultados del TNAT. El objetivo de aprendizaje #3 se evaluó utilizando datos de facturación administrativa de una versión posterior del programa de entrenamiento de transporte implementado con fondos de CSS. Los datos demográficos y del TNAT cubren el año fiscal 19-21, ya que el programa no proporcionó ningún servicio en el año fiscal 18-19. El programa no rastreó los datos de facturación del año fiscal 18-21, lo que limitó la medida en que se puede cumplir plenamente el Objetivo de Aprendizaje #3. Sin embargo, dado que la financiación del programa de asesoramiento en transporte se transfirió del flujo de financiación del INN al flujo de financiación del CSS en 2022, fue posible recopilar datos sobre la versión actual del programa de asesoramiento en transporte.

Los conjuntos de datos del año fiscal 19-21 se fusionaron en un solo archivo y se limpiaron. Dado que algunos participantes participaron en el programa durante varios años, se identificaron participantes duplicados y se eliminaron del conjunto de datos. Se retuvo a los clientes durante el primer año de la cohorte en el que participaron: por ejemplo, un cliente que participó en las cohortes 2 y 3 sería retirado de la cohorte 3. Se eliminaron un total de 14 entradas duplicadas del conjunto de datos siguiendo este procedimiento.

Objetivo de aprendizaje 1

Evalúe si el uso de la herramienta de evaluación de las necesidades de transporte y la posterior orientación sobre transporte conducen o no a mayores niveles de independencia y recuperación informados por los clientes participantes.

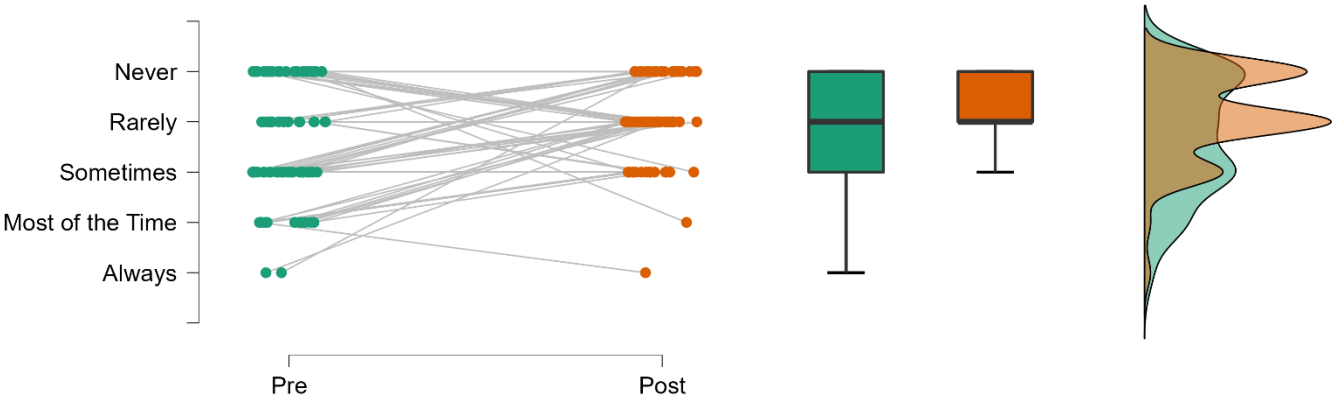
La herramienta de evaluación de las necesidades de transporte (TNAT) y la sesión de asesoramiento en transporte se evalúan en este informe como dos partes de la misma intervención. La independencia y la recuperación se definieron como la medida en que los clientes experimentaron 1) una disminución del número de citas perdidas y 2) un aumento en la frecuencia con la que podían acudir a las citas sin la ayuda de otras personas.

La frecuencia autorreportada con la que los clientes faltaban a las citas disminuyó de antes a la intervención a después de la intervención. La participación en el programa se asoció con un

cambio de .43 puntos en una escala de cinco puntos de la frecuencia autorreportada de faltar a las citas, de un promedio de 3.69 a 4.12 puntos. En términos prácticos, este cambio se debe al hecho de que aproximadamente el 83% de los participantes que indicaron que faltaban a sus citas "siempre" o "la mayor parte del tiempo" en la encuesta previa habían cambiado su calificación a "A veces", "rara vez" o "nunca" en la encuesta posterior a la intervención. Se utilizó una prueba de rango firmado de Wilcoxon[1] con muestras bayesianas emparejadas para probar la hipótesis de que este cambio en la frecuencia autorreportada de ausencias a las citas se debía a un cambio real y no a una variación fortuita en la muestra.[2] Se encontró que la hipótesis (alternativa) de que el cambio de la preintervención a la posintervención no se debía únicamente a una variación fortuita era 18 veces más probable que la hipótesis de que se debía a una mera variación muestral (BF_{10} = 18.479), que normalmente se consideraba "evidencia sólida".[3] Es decir, según nuestro modelo podemos estar seguros aproximadamente en un 95% de que este resultado no se debió a una variación fortuita.

Figura 1. Gráfico del cambio en la distribución de las citas médicas faltantes

Faltar a citas - Faltar a citas POST



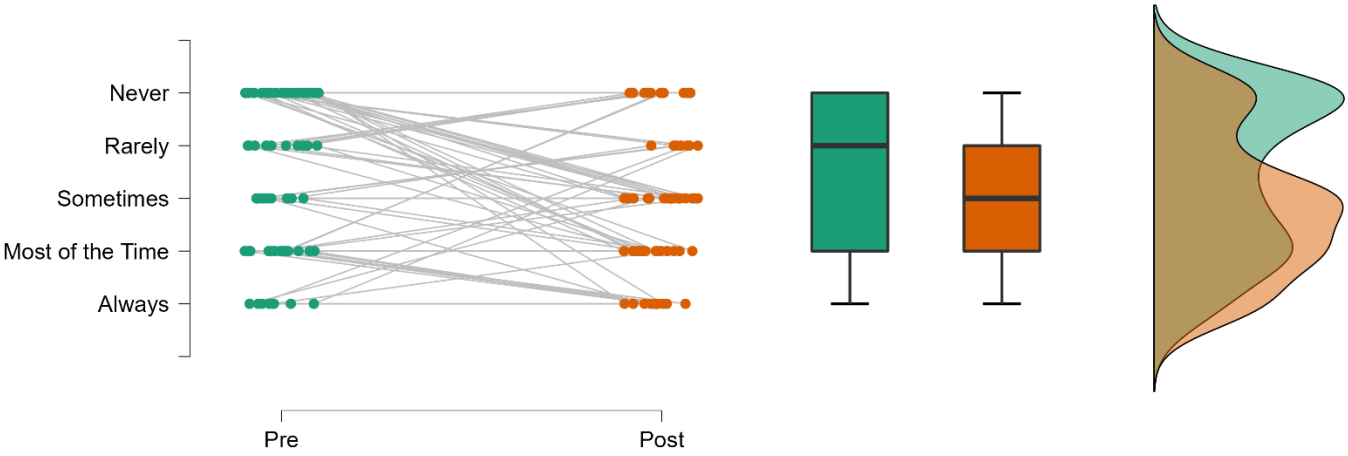
Del mismo modo, la frecuencia con la que los clientes podían acudir a las citas por sí solos aumentó desde el momento anterior a la intervención hasta el posterior a la intervención. La participación en el programa se asoció con un cambio de .62 en una escala de cinco puntos de frecuencia de asistencia a las citas por cuenta propia, de un promedio de 3.49 a 2.87 puntos. En cuanto a las personas, este cambio se debe al hecho de que aproximadamente el 46% de los participantes que indicaron que asistían a sus citas solos ("nunca" o "raramente") en la

[1] Ver: van Doorn, J., Ly, A., Marsman, M., & Wagenmakers, E. J. (2020). Prueba de hipótesis bayesiana basada en rangos para la prueba de suma de rangos, la prueba de rango con signos y la prueba de Spearman. *Journal of Applied Statistics (Revista de estadística aplicada)*, 47(16), 2984-3006.

[2] Se utilizó un Cauchy prior predeterminado con una escala de .707 y centrado en 0 para expresar las débiles expectativas previas de que el tamaño del efecto estaría cerca de 0 y no sería extremo.

encuesta previa a la intervención habían cambiado su calificación a “A veces”, “la mayoría de las veces” o “Siempre” en la encuesta posterior a la intervención. Una vez más, se utilizó una prueba de rango con signo de Wilcoxon con muestras emparejadas bayesianas para determinar la probabilidad de que este cambio en la frecuencia autorreportada de ausencias a las citas se debía a un cambio real y no a una variación fortuita en la muestra. Las probabilidades de que el cambio entre antes y después de la intervención se debiera a un cambio real y no a una variación fortuita se estimaron en aproximadamente 42 a 1, lo que normalmente se considera una evidencia “muy sólida” (BF_{10} = 41.886).[3] En otras palabras, según nuestro modelo podemos estar seguros en un 98% de que este resultado no se debió al azar.

Figura 2. Gráfico del cambio en la distribución de las citas médicas atendidas solo



Según el artículo 3580.020 (a5c), el “Informe final del proyecto innovador incluirá... cualquier variación en los resultados basada en la demografía de los participantes, si corresponde”. Una prueba de independencia fila por columna utilizando tablas de contingencia bayesianas reveló que[4] los participantes no blancos tenían más probabilidades de informar que podían asistir a más citas por sí mismos al final del programa. A modo ilustrativo, el 60% de los participantes no blancos (n = 47) pasaron al menos un nivel para obtener una mayor frecuencia de citas individuales, mientras que solo el 25% de los participantes blancos cambiaron al menos un nivel (n = 28). Mientras tanto, los participantes blancos tenían más probabilidades de no experimentar cambios o una disminución de su independencia durante el período de evaluación. Según nuestro modelo, podemos estar seguros aproximadamente en un 97% de que este patrón no se debe al azar, evidencia que normalmente se consideraría “sólida” (BF_{10},

[3] Jeffreys, H. (1961). La teoría de la probabilidad (3ª edición). New York, NY: Prensa de la Universidad de Oxford.
[4] En este análisis, la raza se recodificó en categorías blancas y no blancas para garantizar tamaños de muestra adecuados para la prueba de hipótesis. El término “blanco” se definió de manera similar a la categoría “solo blanco” utilizada en el censo de los Estados Unidos.

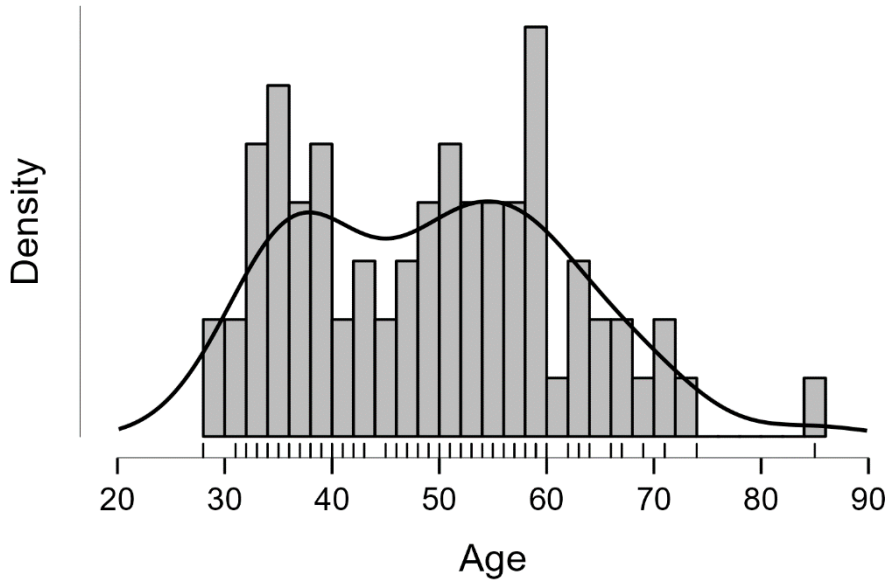
28.539).[3] Sin embargo, utilizando el mismo tipo de modelo, no hubo evidencia de diferencias en la asistencia a las citas por raza.

Tabla 3. Tabla de contingencia de cambios en las citas individuales por raza participante

		Cambio en las citas individuales			
Raza (recodificada)		**Decayó**	**Sin cambios**	**Mejoro**	**Total**
No blanco	Conteo	7.000	12.000	28.000	47.000
	% dentro de la fila	14.894 %	25.532 %	59.574 %	100.000%
Blanco	Conteo	10.000	11.000	7.000	28.000
	% dentro de la fila	35.714%	39.286%	25.000%	100.000%
Total	Conteo	17.000	23.000	35.000	75.000
	% dentro de la fila	22.667 %	30.667 %	46.667 %	100.000%

Del mismo modo, se utilizó una prueba bayesiana de independencia de filas y columnas para comprobar si los resultados del programa diferían según la edad. Los participantes se dividieron según la edad promedio, aproximadamente 50 años. Los participantes menores de 30 años no estuvieron bien representados en la muestra, lo que significa que el hallazgo antes mencionado con respecto a la edad debe tratarse provisionalmente. No hubo evidencia de una diferencia de edad entre los participantes en ninguno de los dos resultados clave.

Figura 3. Distribución de las edades de los participantes en la muestra



Objetivo de aprendizaje 2

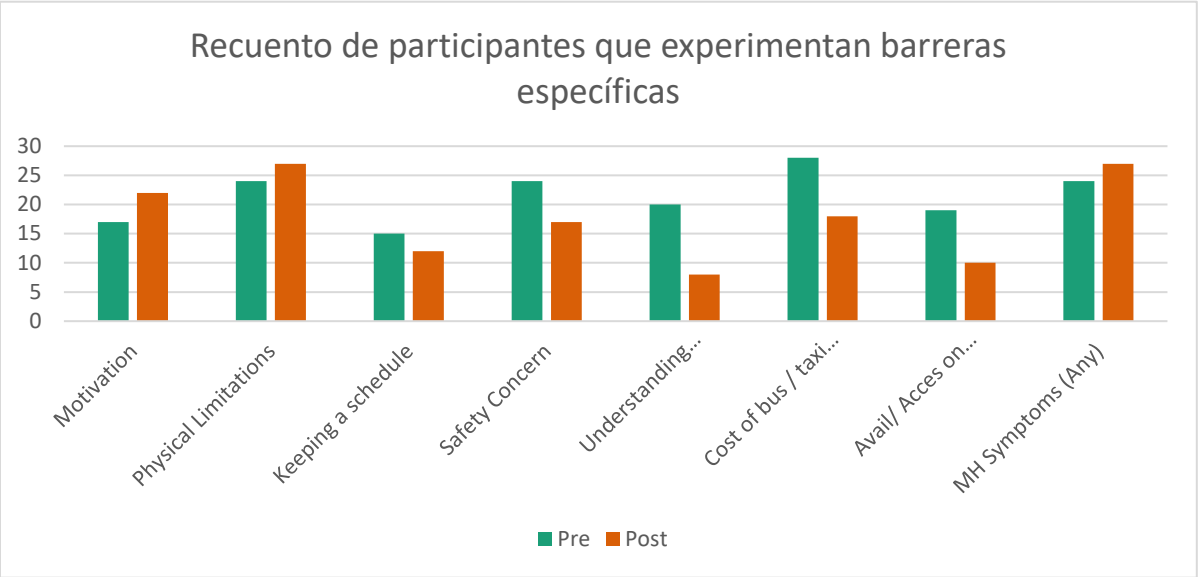
Identifique qué actividades de asesoramiento de transporte corresponden a mejores niveles de independencia y recuperación.

Para identificar las actividades que se corresponden con mejores niveles de independencia y recuperación, se calcularon las puntuaciones de cambio para cada elemento del plan de estudios abordado (es decir, las "barreras"), así como para los resultados de la frecuencia de las citas perdidas y las citas individuales. Se construyeron tablas de contingencia para investigar si las puntuaciones de cambio en aspectos del plan de estudios estaban asociadas con las puntuaciones de cambio en los resultados de interés. Si los cambios en las puntuaciones del plan de estudios en cualquiera de los dominios evaluados (por ejemplo, la creación de un horario) estuvieran asociados a cambios en los resultados, esta diferencia se destacaría como una dependencia entre las variables categóricas. Se utilizó una prueba bayesiana de independencia entre filas y columnas con un esquema de muestreo de Poisson y antecedentes[5] predeterminados para probar la hipótesis (alternativa) de que existía una relación entre el cambio en cualquier "barrera" curricular y los cambios en las variables de resultado. Se realizaron ocho pruebas para cada variable de resultado para un total de 16 pruebas. En ninguna prueba se encontró evidencia a favor de la hipótesis alternativa; todos los resultados proporcionaron evidencia a favor de la hipótesis nula o sugirieron que no había suficiente información disponible para determinar la probabilidad de las hipótesis. Por lo tanto, en la

[5] Jamil, T., Ly, A., Morey, R. D., Love, J., Marsman, M. y Wagenmakers, E.J. (2017). Factores de Bayes predeterminados "Gunel y Dickey" para las tablas de contingencia. *Behavior Research Methods (Métodos de investigación del comportamiento)*, *49*(2), 638-652.

actualidad, si bien podemos detectar un cambio en los resultados de interés (faltar a las citas y asistir a las citas solo), no se encontró que estos cambios estuvieran asociados con cambios en los constructos a los que se dirige el plan de estudios. Este hallazgo sugiere que se desconoce el mecanismo por el cual se alcanzan los resultados del programa o que las medidas actuales no son lo suficientemente sensibles a los cambios.

Figura 4. Barreras experimentadas por los participantes antes y después de la intervención



El número promedio general de barreras experimentadas por los participantes no cambió significativamente entre la preintervención y la posterior a la intervención. Como ilustra la figura 4, esto fue el resultado de una redistribución de las barreras de los elementos que se muestran en el lado derecho al lado izquierdo del gráfico. Por ejemplo, si bien los participantes tenían menos probabilidades de indicar que entender el transporte público era un obstáculo después de la encuesta que en la encuesta previa, tenían más probabilidades de indicar que la motivación era un obstáculo, en cambio. Esta reasignación de barreras se parece al efecto de apretar un globo: al comprimir un lado del globo parece que solo se infla su otro lado.

Objetivo de aprendizaje 3

Cuantifique los costos de personal y la inversión asociados con la mejora del nivel de independencia de los clientes (es decir, “reducir” el nivel de necesidades de asesoramiento en transporte).

Se utilizaron datos de una versión de 2022 del programa de entrenamiento de transporte para calcular el costo promedio por participante. En el período estudiado, de julio a noviembre de 2022 (133 días) el personal dedicó un total de 23.9 horas a la capacitación en transporte. En promedio, el personal dedicó 5.39 horas a realizar actividades de entrenamiento en cada

período de 30 días. Por cliente, la cantidad de tiempo dedicado a las actividades de coaching osciló entre 12 minutos y más de 8 horas, con un promedio de 1.99 horas por cliente.

Los "navegadores de bienestar" son el personal encargado de llevar a cabo las actividades de asesoramiento sobre transporte. La información salarial de Wellness Navigators muestra que el rango salarial para este puesto es de $19.43 a $26.07 por hora. Tomando un punto medio entre la parte superior e inferior de este rango salarial ($22.75), podemos calcular el costo promedio por cliente del asesoramiento en transporte: $45.31. Sin embargo, dado que tanto los salarios como el tiempo por participante varían, este gasto potencial osciló entre $19.63 y $219.77 por cliente durante el período de evaluación. Dado el promedio de 5.39 horas por período de 30 días, una organización puede esperar gastar entre $104.75 y $140.54 al mes en asesoramiento de transporte.

Al tomar el costo promedio por cliente ($45.31) y la reducción promedio de las necesidades de transporte de los clientes, es posible estimar la rentabilidad del programa. Si bien hay varios indicadores disponibles en el TNAT para estimar el efecto del programa, se eligió la frecuencia de las citas perdidas para resumir estos efectos. Una razón para centrarse específicamente en la falta de cita es el alto costo de la falta de cita, que según un estudio popular ascendió a $200 en 2017 ($243 en 2022).[6]

Nuestro estudio sobre el programa de asesoramiento en transporte reveló que la participación en el programa se asoció con un cambio de .44 puntos en una escala de cinco puntos de la frecuencia autorreportada de falta de citas, de un promedio de 3.74 a 4.17 puntos. En términos prácticos, este cambio se debe al hecho de que aproximadamente el 83% de los participantes que indicaron que faltaban a sus citas "siempre" o "la mayor parte del tiempo" en la encuesta previa habían cambiado su calificación a "A veces", "rara vez" o "nunca" en la encuesta posterior a la intervención. Se encontró que la hipótesis de que este cambio de la preintervención a la posterior a la intervención no se debía únicamente a la variación aleatoria era 18 veces más probable que la hipótesis de que se debía únicamente a la variación aleatoria (BF_{10} =18.479). En el diseño original de la evaluación del Programa de Transporte, los administradores del programa tenían previsto recopilar el número real de citas perdidas por cliente. Sin embargo, debido a un error, no se recopilaron estos datos. Como resultado, el alcance de los ahorros de costos del programa solo puede estimarse mediante la medida sustitutiva de la conducta autorreportada de ir a las citas.

Teniendo en cuenta la información anterior, el costo promedio de cambiar el comportamiento de los participantes para que falten a menos citas es de aproximadamente $45. En comparación con la estimación, que se cita con frecuencia, de más de $200 en costos asociados con la falta de citas, una sesión de asesoramiento sobre transporte que evite incluso la falta de una sola cita generaría un retorno de la inversión favorable.

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[6] Gier, J. (2017). La falta de citas cuesta al sistema de salud de los Estados Unidos $150 mil millones cada año. *Health Management Technology (Tecnología de gestión de la salud)*, 2.

Conclusiones y recomendaciones

Los clientes que participaron en el entrenamiento de transporte utilizando el TNAT tenían menos probabilidades de faltar a las citas y tenían más probabilidades de asistir a las citas por su cuenta. Sin embargo, no fue posible determinar con certeza qué aspectos del plan de estudios de entrenamiento de transporte condujeron a este cambio. El costo promedio de cambiar el comportamiento de los participantes para que falten menos citas se estima en aproximadamente $45, dados los cambios promedio en el comportamiento de los participantes autorreportados y los costos promedio por participante.

Según el artículo 3580.020 (a5c), el "Informe final del proyecto innovador incluirá... cualquier variación en los resultados basada en la demografía de los participantes, si corresponde". Nuestro análisis sugiere que los participantes no blancos tenían más probabilidades de beneficiarse del Programa de Transporte en el sentido estricto de que tenían más probabilidades de asistir a las citas solos después de la capacitación. Sin embargo, sin más información para dilucidar la posible causa de esta diferencia, este resultado debe considerarse con cautela. El programa también parece haber tenido un impacto positivo en los participantes blancos y no blancos, ya que ambos grupos tenían menos probabilidades de denunciar la falta de citas. Los beneficios del programa parecen distribuirse de manera uniforme entre los miembros de diferentes cohortes de edad, aunque los participantes más jóvenes no estuvieron bien representados en la muestra.

El TNAT fue eficaz al mostrar los cambios autorreportados en las citas faltantes y en las citas asistidas por cuenta propia. Además, el TNAT parece haber servido como una guía útil para los navegadores de bienestar. Sin embargo, se recomienda revisar el TNAT y el método de puntuación. Actualmente, la puntuación TNAT combina elementos de las distintas necesidades y comportamientos de los participantes en una sola puntuación compuesta. Desde una perspectiva práctica, es probable que este método de suma no sea necesario para determinar las necesidades de los participantes. En cambio, se recomienda que Wellness Navigators realice un examen cualitativo de las respuestas a los artículos para guiar el futuro asesoramiento sobre transporte.

Appendix A – TNAT

Transportation Needs Assessment Survey

MHSA Innovations Project

Avatar#:_____ ***Date:***_____

1. How often do you miss your health appointments due to transportation issues?
☐ Always ☐ Most of the time ☐ Sometimes ☐ Rarely ☐ Never

2. How often do you get to your appointment on your own, without the help of another person?
☐ Always ☐ Most of the time ☐ Sometimes ☐ Rarely ☐ Never

3. How often do you go out for other activities that support your wellness and recovery?
☐ Always ☐ Most of the time ☐ Sometimes ☐ Rarely ☐ Never

3a. Which types of activities would you like to do/attend on your own? *(select all that apply)*
- ☐ Errands/Shopping (grocery store, bank, etc.)
- ☐ Religious
- ☐ School
- ☐ Work/Volunteering
- ☐ Sports/Leisure Activities
- ☐ Social Outings
- ☐ Other (Please specify:_____)

4. How do you currently get around?
(select all that apply)
- ☐ Walk
- ☐ Bike
- ☐ Drive myself
- ☐ Driven by friend/family
- ☐ Driven by mental healthcare worker
- ☐ MST
- ☐ MST Rides
- ☐ CCAH (Medi-Cal Transportation Benefit)
- ☐ Taxi
- ☐ Rideshare app (Uber, Lyft)
- ☐ Other (Please specify:_____)

5. How would you like to get around?
(select all that apply)
- ☐ Walk
- ☐ Bike
- ☐ Drive myself
- ☐ Driven by friend/family
- ☐ Driven by mental healthcare worker
- ☐ MST
- ☐ MST Rides
- ☐ CCAH (Medi-Cal Transportation Benefit)
- ☐ Taxi
- ☐ Rideshare app (Uber, Lyft)
- ☐ Other (Please specify:_____)

6. What prevents you from traveling, or makes travel difficult for you?
(select all that apply)
- ☐ Motivation to get out of the house
- ☐ Physical Limitations
- ☐ Keeping a schedule for myself
- ☐ Safety concerns (Please specify:_____)
- ☐ Understanding public transit system (schedules, routes)
- ☐ Cost of bus and/or taxi fares
- ☐ Availability/Accessibility of public transportation
- ☐ Mental health symptoms (Please specify: _____)
- ☐ Other (Please specify:_____)

7. Are you aware of low or no-cost rideshare programs? ☐ Yes ☐ No
(If yes, please specify:_____)

8. Are you interested in using low- or no-cost rideshare programs? ☐ Yes ☐ No

Screening to Timely Access Annual Evaluation Summary Final Report

January, 2023

EVALCORP
Measuring What Matters™

MONTEREY COUNTY BEHAVIORAL HEALTH
Avanzando Juntos Forward Together

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Introduction

Monterey County Behavioral Health (MCBH) created the "Screening to Timely Access" as part of the multi-county "Tech Suite Collaborative", which was branded as "Help@Hand". Within this collaborative, counties brought forward and/or tested mental health technologies. Monterey, specifically, created a self-assessment and referral tool called "WellScreen Monterey" (WellScreen). The project was designed to develop a comprehensive web-based mental health assessment application that can screen for a broad spectrum of mental health disorders and refer individuals to the appropriate level of care within the MCBH system. The goal of this application is to continue to expand the MCBH reach in the community and help reduce the amount of time spent on the assessment as MCBH can use the screening tool to get people into the correct level of care. This screening tool will help educate people about their level of need and the resources available to them. The five-year project began in 2019 and ends in December 2023. The project is funded with Mental Health Services Act Innovation funding.

EVALCORP is contracted by MCBH to evaluate the impact of the WellScreen project. EVALCORP's engagement in the evaluation began in 2022. This report includes program-related information, as well as an overview of the evaluation methods and findings for FY 21/22.

Screening to Timely Access Project

The primary problem addressed by this Innovation project is demand for mental health services outpacing the capacity of mental health services system to appropriately screen and refer these individuals to treatment. MCBH organizes its "Systems of Care" in three areas: (1) adult services, (2) children's services, and (3) ACCESS services. The ACCESS System of Care includes gateway early intervention services, including assessment and referrals, for individuals expressing symptoms of mental illness. MCBH's access to treatment services are both a level of care for people with moderate disorders and a gateway into intensive services. The demand for services in ACCESS programs has seen a significant increase in recent years, with the number of clients served over the three-year period from FY2015-17 increasing by more than 100%, from 2,521 to 5,087. Meanwhile, the level of staff capable of responding to these community needs has remained unchanged. The MCBH community planning processes have also revealed both a lack of knowledge in the community about available mental health services and a persistent stigma associated with mental health issues, particularly among Latino communities. Therefore, MCBH believes demand for these ACCESS services will only continue to increase over time.

The goal of this project is to develop a new web-based screening tool that will help individuals understand their potential needs and quickly connect them to appropriate treatment. The tool was built independently of any existing MCBH or Technology Suite applications, only potentially linking with Technology Suite applications at a future date where feasible and applicable. It is designed for people 16 years old and older and is available in English and Spanish.

The tool was developed around the core criteria of:
• Being able to screen for a broad range of disorders, from low-risk with mild need to severe with urgent need.
• Being easily accessible for use by community-based providers to help individuals understand the need for treatment.
• Maintaining confidentially standards.
• Interfacing with MCBH's Avatar electronic health record system to provide more seamless transitions into care.
• Working fluidly in Spanish. The screening tool will incorporate perspectives from the Latino community and will include cultural nuances that reflect how Latinos understand and relate to mental health.
• Build upon current evidence-based screening tools with proven validity and utilize item response theory to minimize the number of questions involved in the assessment. By using the web-based screening tool, the type and severity of mental health concerns will be identified along with the corresponding MCBH treatment program that best fits their needs. The user will be provided the option to view the appropriate referral contact information or transmit health information to MCBH for review and a callback by MCBH staff (Figure 1).

Figure 1. Project Overview

The main learning goal of this project is to determine if this project increases access to mental health services in Monterey County. To assess the relationship between use of this application and greater accessibility to services, and its value to consumers/users more generally, the following learning goals are being evaluated:
• Determine if this screening tool accurately gauges type and severity of mental illness.
• Determine if this application provides meaningful and accurate referral connections to the appropriate service / resource as efficiently as possible.
• Assess whether this web-based screening tool reduces the hours and cost associated with in-person assessments.
• Assess the impact the implementation of this application has on the total volume of clients entering ACCESS services, including its effect on the demographics of clients served.
• Assess whether individuals (staff, community provider, peer, etc.) using this application to assist a person in need find this application useful for connecting that person to resources. Many local agencies expressed interest in testing this, including local law enforcement, who hope to use this to link community members to care.

Evaluation Methods

The WellScreen evaluation is designed to answer the learning and evaluation questions posed for the project and includes both qualitative and quantitative data collection strategies. To evaluate the impact and value of the application proposed in this project, quantitative and qualitative methodologies will be used. Through evaluation efforts, application data on user demographics, assessment data, and referral data will be assessed and utilized for various evaluation strategies. To measure if the application accurately gauges type and severity of mental illness, follow-up surveys and/or cross-reference with Avatar service data will be conducted. A similar methodology will be used to assess the efficacy of referral/linkage functions of the application. To measure for any reduction in staff hours spent on assessment/evaluation of clients, the corresponding Avatar data concerning staff hours spent on these service activities will be analyzed. Avatar data also will be referenced to assess the aggregate impact that use of this application may have on increasing total number of clients served. Finally, qualitative information will be gathered to assess user experience. This information will be requested from the spectrum of users. Possible users include clinical and law enforcement staff, community providers, consumers, Promotors/community health workers, and access line staff.

The project stage during FY 21/22 was the development of the screening tool. Therefore, the focus of this report is to describe the development and evaluation process used to create and test the tool and to summarize the data. The data source was existing documents developed by MCBH and CredibleMind, who is the vendor creating the screening tool.

Limitations

As with any evaluation, the WellScreen assessment confronted limitations imposed by circumstances. The EVALCORP team was not involved in the research conducted to create the screening tool. In addition, the findings are based on documents not developed by EVALCORP.

Findings

The development of the screening tool began with MCBH creating a request for proposal to identify the vendor to develop the tool (Appendix A). Proposals were due in February 2021. In the request for proposal the required conditions to identify for (at minimum) were:

1. Depression
2. Bipolar disorder
3. Schizophrenia
4. Psychosis
5. Post-traumatic stress disorder (PTSD)
6. Anxiety disorders
7. Substance abuse disorders

The vendor selected was CredibleMind. Their scope of work was completed in August 2021 (Appendix B). In October 2021 CredibleMind completed a research plan (Appendix C). The research plan provided an outline for the tasks and activities CredibleMind would undertake to fulfill research goals outlined in the statement of work.

In March 2022 CredibleMind submitted their research report that included the results of the environmental scan, literature review, needs assessment, and behavioral systems mapping (Appendix D). The needs assessment survey (n=32) inquired about additional conditions, other than the required seven, to include in the screening tool. Eighty-one percent of respondents (n=26) suggested suicide ideation was extremely important for this survey tool followed by postpartum depression (44%, n=14). Half responded that eating disorders (n=16) was very important followed by autism spectrum disorders (47%, n=15). The survey also included a list of factors that impact behavioral health as these items were also being considered to be added to the screening tool. The most frequently selected items were history of trauma (100%, n=32) followed by food insecurity and physical health (84%, n=27). Appendix E contains all of the survey results.

Following the research, a function design document (Appendix F) was developed. The purpose was to develop user personas and journeys for the screening application. These elements reflected the need for a responsive design that adapts easily for anonymous users so that the application can be used by infrequent users without training. The confirmatory findings were:
1. Users appreciated the visual appeal of the initial home page.
2. Users appreciated the option to start the screening process in Spanish (some users were bilingual and non-Spanish speakers also commented on the value of this option).
3. Users confirmed they are generally willing to answer the questions that were posed as representative of the entire screening tool.
4. Users understood the summary of their results displayed by levels of concern. Some showed interest in learning more about the various conditions.
5. Users understood conceptually that in addition to viewing results they could be directed to services and they had an appreciation for the overall concept of being guided to services.

The key findings and mitigations were:
1. **Home page** - Ability to enter an access code confused one user. “Do I need an Access Code to access the screener?”
a. Mitigation - The developed version includes an Access Code section text changes for retesting.
2. **Sample question Likert format** - Likert-scale questions appearing in varying orders is more confusing to some users. One commented on the varying order and another commented on the design layout not being as friendly as radio buttons. If validated scales offer flexibility, consistency is preferred. A stakeholder also mentioned that Likert-scales may not resonate for various user groups.
a. Mitigation - Continued research and further testing to reveal the best design going forward.
3. **Sample questions context** - users commented that they desired to know why they are

being asked certain demographic questions.
a. Mitigation - The final design included a plan for better context and descriptions for retesting.
4. **Referral calls to action** - users were confused by the QR Code option for accessing results. Users asked again what they should share on a call or bring when they walk in.
a. Mitigation - A new design without a QR Code and with better instruction text may focus users on their next steps and can be retested.
5. **Results options** - users preferred to have results emailed to them. The results page was suggested as the primary time to request sign-up vs upon question completion before seeing results.
a. Mitigation - The submit button order was changed based on this feedback.
6. **Results detail** - users expressed an interest in learning more about each condition and their scores. The results sections may include self-care resources and, based on interest, may be better presented without a collapsed accordion.
a. Mitigation - These options are configurations and can be retested.
7. **Hours and locations** - users like this feature and requested that location be optionally detected vs entered. Users want links to Google Maps. Users also want to have access to a phone number.
a. Mitigation - Development plans included user location detection and research on Google Map linking.

CredibleMind then created the technical documents (Appendix G). The purpose was to document the technical design of the solution for the screener for referrals. Included is information about topics such as workflow, data design, system architecture, and a data dictionary.

All of this work in FY 21/22 culminated in a draft screening tool (Appendix H), which was actually developed in July 2022, so in FY 22/23. It is included in this report as that it the apex of all of the year's work in FY 21/22.

The draft screening tool takes approximately 10 minutes to complete and is written in English and Spanish. The conditions and question counts are identified in Table 1.

Table 1. Conditions and Question Counts

Category/Condition	**Minimum number of questions**	**Maximum number of questions**
Anxiety	2	7
Depression	2	9
Postpartum depression	0	10
Trauma/PTSD	1	6

Bipolar	8	11
Psychosis	8	16
Substance-induced bipolar or psychosis	0	2
Eating disorders	5	5
Substance use		
- 21 and older	5	31
- Under 21	5	20
Demographics	15	15
TOTAL for non-pregnant youth	**46**	**91**
TOTAL for non-pregnant adult	**46**	**102**

The screener questions are in a branching format so that users are not asked irrelevant questions. The response options are multiple-choice to make the time for completion and data analysis more streamlined.

Discussion

This project is expected to assist Monterey County residents and those who provide services to the community members by providing a mental health assessment screening tool available 24 hours a day, seven days a week. The increased need for services has created challenges for access to services that this tool is designed to addressed. It also will provide information about mental health conditions and resources in a discrete manner to help reduce the impacts of stigma. Lastly, the tool will refer users to the appropriate level and place for care. MCBH can also use the data collected to assist the county with identify trends in mental health conditions in a timely manner. That timely information can be used to pivot funding streams and services and minimal that delay in responding to changing community needs.

The development of the draft screening tool has been thoughtful, comprehensive, and evidence based. MCBH and the vendor conducted an extensive amount of research on screening tools, community needs, and services in the community. This information was included into the design and content of the screening tool. The tool was tested and changes made accordingly.

Summary

The WellScreen project is innovative and is expected to address a major problem, which is the higher need for services and providers being at capacity. It will also assist with barriers to care such as stigma and not knowing about resources in the county. Lastly, it can provide real-time data to the County about trends in the community. In FY 21/22, MCBH and their chosen vendor engaged in a systematic and research-based process to develop the draft screening tool.

Appendix A: Request for Proposal to Develop Screening Tool

Request for Proposal Help@Hand Screening Tool Project

Applications due by 5:00pm on Thursday, February 18, 2021

MONTEREY COUNTY BEHAVIORAL HEALTH

Avanzando Juntos Forward Together

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH

hope. recovery. wellbeing.

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Project Background

The California Mental Health Services Authority (CalMHSA) is an independent administrative and fiscal government agency focused on the efficient delivery of California mental health projects. CalMHSA was established by California counties in June 2009, as a Joint Powers Authority (JPA). CalMHSA's member counties work together to develop, fund, and implement mental health services, projects, and educational programs at State, regional, and local levels. CalMHSA is headed by a separate Board of Directors composed of representatives of Member Counties and an Executive Committee comprised of officers and Statewide Regional Representatives. CalMHSA operates within the statutes governing JPA entities and complies with the Brown Act open meeting requirements.

CalMHSA, with the support of participating counties and cities has implemented a project called Help@Hand, which aims to build a complementary support system that offers a bridge to care, helps identify early signs of mental health changes, offers timely support, removes barriers, and seeks to include new avenues of care for communities not connected to conventional county services. Monterey County Behavioral Health (MCBH) and Los Angeles County Department of Mental Health (LACDMH) are two of the participating members of the JPA. CalMHSA, MCBH and LACDMH are working collaboratively to solicit responses to meet a need initially for Monterey County and Los Angeles County.

This Request for Proposal is intended to solicit interested parties with the ability and capacity to perform the services requested, with the intent to award a contract to the selected entity. However, there is no guarantee of a contract, as we are facing unprecedented times which could dictate otherwise for CalMHSA's participating members.

Primary Problem

The primary problem being addressed by this project is the demand for mental health services outpacing the capacity of the mental health services system to appropriately screen and refer these individuals to treatment. MCBH, who is the originator of this project, organizes its "Systems of Care" in three areas: Adult services, Children's services and ACCESS services. Their ACCESS System of Care includes gateway early intervention services, including assessment and referrals, for individuals expressing symptoms of mental illness. The demand for services in ACCESS programs has seen a significant increase in recent years, with the number of clients served over the three-year period from FY2015-17 increasing by more than 100%, from 2,521 to 5,087. Meanwhile, the level of staff capable of responding to these community needs has remained relatively unchanged. The MCBH community planning processes have also revealed both a lack of knowledge in the community about available mental health services and a persistent stigma associated with mental health issues, particularly among Latino communities. MCBH believes demand for ACCESS services will continue to increase over time. Additional counties, including Los Angeles County, are experiencing similar challenges.

Several mobile applications that promote mental health and wellness have entered the market space in recent years. However, a thorough scan of available products has only found two varieties of application functionality. The first is to provide guided meditations. The second is to provide the user an ability to log and rate their emotional state. No applications were discovered that have the functionality to screen for a broad spectrum of mental health disorders ranging from depression to schizophrenia, nor were any capable of providing MCBH or LACDMH referral resources. To better meet the increased demand for services, MCBH and LACDMH have proposed the development of a comprehensive web-based mental health assessment application that can screen for a broad spectrum of mental health disorders and refer individuals to the appropriate level of care within the local mental health system.

User Scenarios

The following user scenarios highlight the general user profile (including type of user and technical competency), the need or purpose of that user, and their desired result. These user scenarios are intended to highlight the end user characteristics and desires to be positively influenced by the target solution.

User Profile	Need	Desired Result
 Description: Family Member/Friend of an Individual that Experiences a Mental Health Disorder Technical Competency: Medium (Difficulty in navigating new applications, but has good smartphone, tablet, and laptop navigation capabilities).	A family member/friend of an individual experiencing symptoms of a mental health disorder can pull up this application on their phone or computer and guide their loved one through the screening tool.	The individual (and their family member / friend) will be educated on the symptoms they are experiencing, associated risks and treatment options, and local resource information.

 Description: Individual entering Mental Health Clinic or taking assessment without support from others. Technical Competency: Low (Difficulty in navigating new applications and lack of experience in smartphone, tablet, and laptop navigation capabilities).	An individual is entering a County mental health clinic for the first time or taking the assessment alone. As part of the check-in procedures, the individual is asked to complete the web-based screening tool on their phone (or provided tablet) to expedite and/or inform the clinical intake/assessment person, or to advise the individual of resource options.	The individual is "warmed up" to the clinical assessment process with exposure to mental health screening questions and subsequent results. Additionally, the clinician and individual can review the results in order to expedite the treatment plan by reducing redundancy with clinician intake procedures.
 Description: Community Service Provider conducting outreach activities Technical Competency: High (Fully capable in navigating new applications and in the use of smartphone, tablet, and laptop navigation).	A community service provider performing education and outreach activities can utilize this screening tool with clients/participants expressing urgent needs for services for themselves or their clients.	The community service provider is equipped with an education and referral tool to assist individuals in need, while the individual is educated on symptoms and local resources.

Purpose of RFP for Services

To better meet the increased demand for services, MCBH and LACDMH have proposed the development of a comprehensive web-based mental health assessment application that can screen for a broad spectrum of mental health disorders and refer individuals to the appropriate level of care within the local mental health services system. MCBH and LACDMH are soliciting responses to identify and select a vendor to design and develop an evidence-based assessment tool comprising a series of questions that provide the user with an assessment score in a variety of mental health categories. Following the assessment, the

type and severity of mental health symptoms will be identified along with corresponding treatment program options that best fit their needs. The tool will be developed around the core criteria of:

- Being able to screen for a broad range of disorders, from low risk with mild need to severe with urgent need.
- Being easily accessible for use by community-based providers to help individuals acquire treatment.
- Maintaining confidentiality standards.
- Working fluidly in Spanish.
  Build upon current evidence-based screening tools with proven validity and utilize item response theory to minimize the number of questions and time involved in the assessment.

Project Scope Overview

This project will be executed across two (2) key phases; DESIGN and TECHNOLOGY for the vendor. The IMPLEMENTATION phase will be a multi-organization effort coordinated at CalMHSA in conjunction with the Design and Development phases. There is a Scope of Work for each Design and Technology phase. A proposing firm must propose for the Scope of Work for both phases.

Example 1: Project Scope

The entire scope of services outlines the design, development and implementation

Design Scope of Work

This Scope of Work will rely on best practice knowledge of research-based tools for mental health diagnosis. The goal of this phase is to design a sound and effective self-assessment that an individual can take on their own, that will direct the consumer to additional resources and options based on the conclusions drawn from the assessment. This screening tool must contain business rules and question trees, guiding the user to answer questions relevant to them based on indicators. The vendor will include clinical and design subject matter experts.

The screening tool must meet the following requirements:

1. Screening tool with questions and answers drawn from existing best-practice and standard behavioral health assessment tools
2. Leverage non-proprietary open source tools in combination with adjustments as needed
3. Avoid duplication of questions if multiple tools are leveraged
4. Lead to possible condition identification in the following areas (at minimum):
    a. Depression
    b. Bipolar Disorder
    c. Schizophrenia
    d. Psychosis
    e. PTSD
    f. Anxiety Disorders
    g. Substance abuse disorders
5. Be written in English and Spanish
6. Result in recommendations for appropriate local mental health resource information.
7. Result in descriptions of the possible condition with informative information
8. Require a User Agreement to be acknowledged by end Conduct Research

The services under this Scope of Work must include the following components of developing this tool:

1. Research
2. Design
3. Evaluation and Refinement

Deliverables

#	Deliverable
1	Project Plan & Schedule
2	Conduct Research
3	Functional Design Document
4	Testing Plan
5	Training Materials

The scope of services is to design a screening tool that allows individuals to take self-assessment, that will lead to a possible condition identification and make soft referrals to supporting agencies within Monterey County and Los Angeles County. The Scope of Services is to involve the following key tasks:

Deliverable 1 - Develop Project Plan & Schedule

a. Plan should include plan for each design key project task, phase, and deliverable
b. Plan should include a design phase project schedule, work breakdown structure, resources, risk management plan, quality plan, change management plan, and project escalation path for the design phase of the project.

Deliverable 2 - Conduct Research

c. Research should include analysis of existing tools, studies of self-assessments, as well as research and interviews of stakeholders and County staff in coordination with CalMHSA

Deliverable 3 - Functional Design Document

d. Create a design document in collaboration with the Technology Services Provider to outline relationships between functionality and design requirements including workflows through the screening process
e. As part of this proposal submittal, provider is to submit a range of time which the assessment tool is estimated to be completed by the user. For example: "The full assessment tool is estimated to take between x minutes (minimum) and y minutes (maximum) to complete". Consideration should be made to design an assessment tool that is extensive enough to deliver an effective outcome, but not so exhaustive that users fail to complete it due to an excessively lengthy process. Please provide an estimation of time it would take an end-user to complete the assessment.

Deliverable 5 - Training Materials

f. A cohort of CalMHSA, County staff and community-based service providers will be trained in the use of the tool. Similar user-testing may take place in Los Angeles as well. These trained individuals will then pilot screenings in the field, using the application with a small number of clients to ensure its applicability in their local communities, and assess functionality and user experience. The goals of the Evaluation Phase will include:

    - Determine if this screening tool accurately gauges type and severity of mental illness.
    - Determine if this application provides meaningful and accurate referral connections to the appropriate service / resource as efficiently as possible.
    - Assess whether this screening tool reduces the hours and cost

associated with in-person assessments.

- Assess whether individuals (staff, community provider, peer, etc.) using this application to assist a person in need find this application useful for connecting that person to resources.
- Assess the impact the implementation of this application has on the total volume of clients entering services including its effect on the demographics of clients served.

The evaluation phase will include both steps for validation and refinement as identified below:

1. Validation
    a. Validation of the tool should involve dissemination of the screening tool to Monterey and Los Angeles residents and staff
    b. Monterey and Los Angeles staff engage with local Community Based Organizations to assist with the dissemination of the screening tool
    c. The vendor shall create the validation plan
2. Refinement
    a. Work collaboratively with CalMHSA, Monterey and Los Angeles Counties to modify and refine the assessment tool after input has been received.
    b. The vendor shall participate in and facilitate the refinement plan

Technology Scope of Work

This phase will rely on a team of technologists to build or configure a mobile compatible web-based questionnaire screening tool which results in a possible condition and soft referrals based on business rules and information as developed in Phase 1.

Vendors should describe the delivery model along with the advantages. Delivery models considered for the required solution may include:

- Commercial off-the-shelf (COTS) software
- Custom built application
- Open-source software (all models)
- Managed services/hosted

The output of this scope of work must include a solution that:

1. Is a responsive web design with the ability to adapt easily across all devices (i.e. desktop, laptop, mobile, etc.)
2. Is on cloud-based infrastructure within cloud instances
3. Is compliant with HIPAA, PHI, PII and other modern security standards including being compliant with FedRAMP Medium standards to include a

third-party assessment of the security standards to ensure compliance with these standards

4. Provides the ability to function consistently across multiple browsers (i.e. Edge, Chrome, Safari)
5. Uses business requirements and business-rules to drive functionality as defined by the Design Scope of Services
6. Captures all assessments and any other required data as identified from the section above (Design Scope of Work)
7. Does not require individual licensing fees
8. Supports multiple languages (i.e. Spanish and English) as identified by participating counties
9. Is intuitive and user friendly
10. Identifies possible condition(s) as defined by the Design Scope of Services
11. Provides the capability to enter, maintain and display local service providers as defined by the Design Scope of Services
12. Complies with ADA and WGAG v2.x or latest
13. Seamlessly scalable to accommodate future growth
14. Supports standard APIs, interfaces, and communication protocols for enterprise application integration systems and/or web services integration to other applications (integration not in scope of this contract). This Scope of Work will not be used to capture consumer health data or to submit claims.
15. Allows individual counties to easily access their respective data for reporting and other business purposes
16. Supports administration of application (i.e. user access control, define user roles, security, maintain lookup tables, etc.)
17. Supports business intelligence and analytical tools

Deliverables

The services executed in this phase should be conducted in an Agile methodology. This phase will initiate before the screening tool has been developed and will require a team to implement screens and business rules. Development efforts in this phase will also require working closely with CalMHSA, in collaboration with Monterey County and Los Angeles County to validate the look and feel of screens, needs for data security and management, and build a platform that could in the future integrate with Monterey and Los Angeles internal systems.

#	Technology Deliverables
1	Technical Documents
2	Application Landscape/Environments
3	Application Prototype
4	Test Strategy and Documents

5 Training Strategy and Documents

6	Production Deployment
7	Post-Go Live Support
8	Data Extracts
9	Status Reporting
10	System M&O

Development or configuration of the application in a Cloud environment using iterative development practices.

Deliverable 1 – Technical Documents

Technical documentation including architecture and code base referenced directly to functional requirements, as well as any hosting or maintenance needs.
Technical documents must include the following:

- Functional Design Document
- Technical Design Document
- Application/System Architecture Document
- Entity Relationship Diagram (ERD)
- Application Workflow
- Data Dictionary

Vendor team shall provide a technical design document, which includes the above listed documents.

Acceptance Criteria

The CalMHSA will accept the completion of the Technical Document per the following acceptance criteria:

1. Business Requirements Document should list all the user stories and requirements and business rules in detail along with any future or enhancement requirements.
2. Technical Requirements document that comprehensively lists the technical details i.e. screen names, field names, data types (numeric vs alphanumeric), etc. This document should also list all the security requirements to comply with various County, state and Federal security policies.
3. Technical Design document that includes user interfaces, wire frames, data flow diagrams, etc.
4. Application System Architecture document that includes Conceptual, Logical Architecture
5. Entity Relationship Diagram should include the table structures and their relationships and dependencies

6. Application workflow should include a detailed flow diagram of the various functions
7. Data Dictionary document that lists all the data fields and their attributes
8. The design document should also include any designs for features not-yet developed, including the relevant Epics, Features, and User Stories.

Deliverable 2 - Application Landscape/Environments

The project should provide the standard application code development/maintenance landscape i.e. Development, Test and Production environments.
Note on Test Environment: Vendor shall provide a test environment specific to the County so that county staff and Peers can test configurations and feature development in a manner that reflects their Production Environment.

Acceptance Criteria

1. A Test Environment that mirrors the Production Environment, but also includes county specific configurations that is accessible through a County Code.
2. The Test Environment should be completely separate from the Production Environment. There should be no way for a user in the Test Environment to be transferred to the Production Environment and vice versa.

Deliverable 3- Application Prototype

The vendor shall develop a working functional prototype of the end state application to be approved by the CalMHSA, Monterey and Los Angeles teams.

Deliverable 4 - Test Strategy and Documents

The vendor shall provide an overall test strategy document along with the following documents:

- Functional Testing Document and test scripts
- Technical testing document and test scripts
- User Acceptance testing document and test scripts
- Integration testing document (if needed)
- Regression testing document (if needed)

The Vendor team shall conduct testing on all developed features, bug fixes, and configurations, and resolve all issues, before code changes are deployed to County test environment. The Vendor team shall report to the CalMHSA Project Manager findings from testing on a regular basis.

UAT Entry Criteria

1. Vendor notifies CalMHSA of any development work performed outside of the Tech Suite that affects county configured environments. (During Sprint Planning)

2. Automated and Manual testing report provided by Vendor
3. Release notes have been provided to CalMHSA by Vendor
4. New features and defect fixes have been migrated to the Test Environment

Acceptance Criteria

1. Any feature developed in the Test Environment pass Regression Testing and User Acceptance Testing prior to being able to deploy into the Production Environment
2. All identified bugs are shared with CalMHSA and ultimately resolved by provider
3. CalMHSA and County Sign-Off on items that pass User Acceptance Testing prior to deployment to the Production Environment

Deliverable 5 - Training Strategy and Documents

The vendor shall provide a detailed training strategy document (i.e. train the trainer, on-site/classroom training, etc.) along with the necessary training materials - Administrator Guides, User Guides, Cheat Sheet, etc. The vendor shall conduct the necessary training as outlined in the training strategy document.

Deliverable 6 - Production Deployment

The vendor shall deploy and configure the application with agreed upon functionality (including any bug fixes and enhancements) in production environment and make it available for production use.

Acceptance Criteria

The CalMHSA will accept the completion of this deliverable with the completion of the following conditions:

1. Working and stable Production Environment is accessible by County with county code
2. Vendor will not push changes to Production that also affect County configured environments without prior approval
3. Production Environment contains all code approved by CalMHSA from Testing Environment for MVP & Configuration needs
4. Production Environment reflects approved Configuration
5. CalMHSA Sign-Off on Production Environment

Deliverable 7 - Post Go-Live Support

The vendor shall provide technical and functional support for 180 days after full production rollout of the application.

Deliverable 8 - Data Extracts

Vendor shall provide the county with periodic data extracts which can be used to support the evaluation of the effectiveness and accuracy of the tool. Data extracts must be part of the product used for testing so that the Design Vendor can assess the effectiveness of the solution. Data extracts must also be available post testing phase and during Go Live so that the system can be continuously evaluated.

Acceptance Criteria

1. Reports will be continually accessible to CalMHSA, County and Design Vendor for evaluation purposes.

Deliverable 9 – Status Reporting

Vendor shall provide the following deliverables per contract requirements:

1. Mechanism for clients to obtain accounting of disclosures of Personally Identifiable Information (PII)
2. Outcome dashboard*
3. Quarterly Status of Deliverables report*
4. Annual Status of Deliverables report*

*These items are to be maintained and reviewed on an ongoing basis.

Deliverable 10 – Maintenance & Operations

This section outlines expectations of the Vendor team to support and maintain a working environment for Vendor users. All features must be maintained to continue meeting acceptance criteria. It is required that CalMHSA will be the sole owner of the application in its Help@Hand form without recurring licensing fees.

Vendor team shall also provide a platform maintenance fee structure for ongoing rollout after MVP (e.g. by bands of users; by number of growth paths completed, etc.).

Agreement Terms

The Agreement will be for one year, and is subject to fund availability. If it is determined funds are no longer available, the Agreement may be terminated without cause or penalties.

The Agreement shall reflect a deliverable based payment structure not to exceed $2.1 million. Respondents are asked to provide a detailed estimate of scope and cost necessary to achieve the goals detailed in the Scope of Work of the Technology development component.

The resulting Agreement will not take effect until fully executed by all parties and all insurance requirements have been met.

Response Contents

The following response components are required as outlined below. CalMHSA is not responsible for costs associated with the development of proposals nor shipping or delivery of such.

Response Contents – General

Please submit the following components as part of your response:

1. Cover Letter (limit 1 page)
2. Background of organization
    a. Describe how your organization is equipped to meet the needs as identified in this Scope of Work and provide three examples of prior work that is similar in scope and complexity to the items outlined in this Scope of Work (limit 4 pages)
    b. Executive Summary of proposed team and organizational structure, including all required key positions and any additional proposed positions (limit 6 pages)
    c. Resumes
        i. Design Staff
        ii. Technology Staff
        iii. Any Additional Staff
    d. Understanding and Approach (limit 30 pages)
3. The vendor must propose a project management tool that will be accessible by CalMHSA and County staff
4. Cost Proposal
    a. The vendor must download and submit a complete "Cost Worksheet" excel file found in Bonfire under "Files."
5. Conflict of Interest Policy
    a. The vendor must download and submit a fully executed "Conflict of Interest Policy." This document can be found in Bonfire under "Files."
6. Proposal Submittal Letter
    a. The vendor must download and submit a fully executed "Proposal Submittal Letter" on their letterhead. This document can be found in Bonfire under "Files."

Response Contents - Design

1. Proposed Team
    a. Identify qualifications of resources for the following key roles
        i. Project Manager
        ii. Lead Researchers
        iii. Identify any additional roles as necessary to complete the Scope of Work

iv. Include resumes for each proposed team member

2. Approach to Scope of Work
    a. Outline approach for conducting all activities related to the Scope of Work
    b. For each task, identify key activities, milestones, deliverables, and work plan
    c. Describe process for maintaining quality of deliverables
    d. As part of this proposal submittal, provider is to submit a range of time which the assessment tool is estimated to be completed by the user. For example: "The full assessment tool is estimated to take between x minutes (minimum) and y minutes (maximum) to complete". Consideration should be made to design an assessment tool that is extensive enough to deliver an effective outcome, but not so exhaustive that users fail to complete it due to an excessively lengthy process.
3. Cost Proposal
    a. Outline each proposed resource, estimated hours per task, and rate used to calculate estimated cost
    b. Define total proposed cost
    c. Contract shall be paid on deliverables
    d. Cost proposal details must be submitted on the Cost Worksheet (Exhibit 1)

Response Contents - Technology

1. Proposed Team
    a. Identify qualifications of resources for the following key roles
        i. Development Manager / Scrum Master
        ii. Lead Developer
        iii. Developer
        iv. Identify any additional roles as necessary to complete the Scope of Work
        v. Include resumes for each proposed team member
2. Approach to Scope of Work
    a. Outline Agile development approach for conducting all activities related to the Scope of Work
    b. For each task, identify key activities, milestones, deliverables, assumptions, and work plan not to exceed 15 months for the Design and Development phases
    c. Describe process for maintaining quality of deliverables
3. Cost Proposal - Services
    a. Outline each proposed resource, per the Cost Worksheet provided in Exhibit 1.
    b. Define total proposed cost
4. Cost Proposal - Materials
    a. Outline the cost to CalMHSA for the environment and other development costs
5. Cost Proposal – Maintenance and Operations – 1 year
    a. Outline the approach to Maintenance and Operations for 1 year to begin directly after implementation of the system on the first day that the system goes live
    b. 1 year of Maintenance and Operations to be included in the overall project and

cost

c. Include details of staff, services, and materials and platform maintenance costs

Roles and Responsibilities

This outlines the roles and responsibilities for each phase of the project.

Design Services

1. Provide overall project management and oversight to the project
2. Create and delivery monthly status reports
3. Facilitate weekly Status meetings and Daily Standups
4. Provide a path for escalation of issues
5. Facilitate and organize meetings with CalMHSA, MCBH, and LACDMH
6. Review deliverables for quality before submission to CalMHSA, MCBH, and LACDMH
7. Create and document survey questions and business rules
8. Document and identify source and rationale for specific questions and logic implemented
9. Work collaboratively with CalMHSA, MCHB, LACDMH, and Technology Vendor throughout the design and validation process
10. Communicate any schedule delays, risks, and mitigation strategies throughout the project
11. Report to the CalMHSA project manager and the MCBH and LACDMH project managers
12. Maintain compliance with research process regulations and engagement with people for the evaluation phase
13. Work collaboratively with all teams

The vendor must utilize an actively licensed psychiatrist as part of the Design team

Technology Services

1. Communication of anticipated or unanticipated risks, delays to the CalMHSA Project Manager
2. Engaging in meetings with CalMHSA and County staff including Daily Standups for the purposes of presenting product demos, validating requirements, assist with design decisions, and general project coordination
3. Establishing clear validation of product and configuration requests
4. Execution of all testing and regression testing to ensure product changes, enhancements, bug fixes, and configurations are developed in accordance with acceptance criteria and do not create new defects
5. Communication and resolution of major faults identified in Production
6. Communication and resolution of down time, blocking issues, and incidents
7. Monitoring of application performance
8. Application security and HIPAA compliance
9. Accessibility and ADA Compliance
10. Spanish and English Language processing
11. Monitoring and maintenance of SLAs

12. Completion of all deliverables identified in the above sections
13. Coordinate meetings and requests through CalMHSA Project Manager
14. Responsive to CalMHSA requests in a timely manner
15. Provide data as needed to Evaluator as related to assessment of product use
16. Provide a solution to support assessment of different types of users; users who were marketed to in different areas, with different materials, or different target populations

Counties of Monterey (MCBH) and Los Angeles (LACDMH)

1. Provide County specific clarification and direction
2. Provide final sign-off of development iterations
3. Participate and sign-off on all primary testing components per the proposed testing and approval methodology

CalMHSA

The CalMHSA as the contract holder, takes responsibility for the following key components:

1. Identify a stakeholder / sponsor individual who can provide "Sign-Off" and make key project decisions
2. Provide a staff who will fill the role of the Product Owner (Voice of the Customer), provide acceptance criteria and accept deliverables
3. Identify a project working team to provide feedback and work with vendor teams
4. Participate in daily standup meetings
5. Coordinate through CalMHSA for vendor requests
6. Participate in testing and provide staff to conduct testing when code is deployed to the test environment
7. Review deliverables and provide feedback in a timely manner
8. Provide overall management of Scope, Timeline and Deliverables
9. Coordinate meetings, work sessions, risks, and documentation
10. Facilitate project decisions with County
11. Provide an escalation path for MCBH and LACDMH
12. Complete User Acceptance Testing (UAT)

Submission Instructions and Requirements
Proposal Timeline

EVENT	Key Dates
RFP Issued	January 11, 2021
RFP Questions Due	January 22 5:00pm PST
Bidders Conference	January 28 9:00am PST
RFP Questions Answered	February 4 5:00pm PST
Deadline for Intent to Bid*	February 8, 11:59 pm PST
Deadline for Proposals to be Submitted	February 18 5:00pm PST
Application Review	Feb 19 –Mar4, 2021

*To meet the Deadline for Intent to Bid requirements, potential vendors must check the "intent to bid" box within the Bonfire Portal. Vendors will not be able to submit proposals if this box is not checked by the deadline.

Submittal Address

All Submissions must be submitted electronically using CalMHSA's e-Procurement Portal: https://calmhsa.bonfirehub.com/.

RFP Questions and Clarifications

All questions and requests must be submitted through CalMHSA's e-Procurement Portal at: https://calmhsa.bonfirehub.com/. The deadline to submit questions for this RFP is January 22, 2021, 5:00 pm PST. The FAQ responding to the questions will be posted on February 4, 2021, 5:00 pm PST at https://calmhsa.bonfirehub.com/ and to the CalMHSA website at www.calmhsa.org.

To ensure all parties have access to the same information at the same time, except as stated below, CalMHSA will NOT respond to questions as they are received and will not accept telephonic questions. CalMHSA will not send out emails following the posting of the FAQ. It is the sole responsibility of the proposer to refer to the FAQs, which will be posted on CalMHSA's e-Procurement Portal at https://calmhsa.bonfirehub.com/.

If a Proposer is unable to submit questions via the Bonfire e-Procurement Portal, the Proposer must provide CalMHSA with an email justification outlining why the Proposer is unable to do so.

Bidders Conference

The Bidders Conference will be held on January 28, 2021 from 9:00AM-11:00 AM via Zoom. The meeting invite will be posted on the CalMHSA website and a link is included here. A recording of the Bidders Conference will be posted to the Bonfire Portal and CalMHSA website by January 29, 2021, 5:00 pm PST. The Bidders conference meeting details are as follows:

Join Zoom Meeting
https://us02web.zoom.us/j/84828010341?pwd=RGlzb1M2M2FqV1lRMWJHc0VKQTBRdz09
Meeting ID: 848 2801 0341
Passcode: 254088
Dial by your location
+1 669 900 9128 US (San Jose)
+1 346 248 7799 US (Houston)
+1 253 215 8782 US (Tacoma)
+1 301 715 8592 US (Washington D.C)
+1 312 626 6799 US (Chicago)
+1 646 558 8656 US (New York)
Find your local number: https://us02web.zoom.us/u/kcO3tknpBt

Withdraw

A proposer may withdraw or amend its proposal, but only before the Application Submittal Deadline, directly on CalMHSA's e-Procurement Portal at https://calmhsa.bonfirehub.com/.

Review of Applications

CalMHSA will receive all applications and review for completeness and adherence to the RFP rules stated in this document. Following the initial review, all qualified applications will be reviewed and scored by a review panel. The evaluation panel will conduct a fair and impartial evaluation of proposals received in response to this RFP.

The review panel is comprised of individuals with varied backgrounds, to include professional expertise, lived experience, personal knowledge, etc. Panelists' information will not be disclosed as a matter of confidentiality. CalMHSA is committed to ensuring the RFP review panel is representative of California's racial, ethnic, and cultural diversity.

Responses will be reviewed and scores awarded on the following best value considerations:

- Understanding and Approach – 40%
- Staffing and Organization – 30%
- Cost – 30%

Non-Collusion

A proposer shall not conspire, attempt to conspire, or commit any other act of collusion with any other interested party for the purpose of secretly, or otherwise establishing and understanding regarding rates or conditions to the solicitation that would bring about any unfair conditions.

Negotiations with Potential Proposers

Selection will not be based exclusively on price. CalMHSA reserves the right to negotiate with proposers who, in the opinion of the review panel, have submitted the best proposal in an attempt to reach an agreement. If no agreement is reached, CalMHSA may negotiate with other proposers or may choose to extend the proposal period. CalMHSA also reserves the right to meet with vendors to gather additional information. Additional information may include, but is not limited to, a demonstration of skills described in the proposal.

Protest Procedures

Protests must be received no later than five (5) business days after the Notice of Intent to Award is posted on the CalMHSA website. The sole bass for protest are that the award was (1) in violation of law, (2) in violation of the provisions of this RFP, or (3) in violation of CalMHSA's procurement process. All protests must be in writing and (1) state in detail each and every ground asserted for the protest, citing to the law, RFP provision, or particular provision of the procurement policy on which the protest is based; (2) explain why the error prevented the aggrieved organization from being awarded the contract; and (3) identify the remedy sought.

Within 14 days of receipt of any protest, CalMHSA's Executive Director will provide a written decision which shall be final upon transmission to the protesting party. If the Executive Director determines that the error identified by the protesting party has deprived that party from receiving the contract, the Executive Director may act to rectify the error, including but not limited to cancellation of the RFP or proposed contract, correction or other revision of the awarded contract, termination of an improperly awarded contract, or affirmation of an existing contract if the discovered defect is immaterial or the Executive Director determines that affirmation is in the best interest of CalMHSA.

Notice Regarding Public Records Act Request

CalMHSA is subject to the Ralph M. Brown Act and the California Public Records Act. All proposals received for this RFP are ultimately subject to public review; however, during the competitive bid process, all proposals will be kept confidential. Upon award and execution of contract by awardee(s), all proposals and supplemental information will be subject to public review, with the exception of those elements of a proposal which contain elements that are clearly marked as confidential or trade secrets. Any such designation should be accompanied by a brief explanation of the reason the information is non-public and protected from disclosure under California law. CalMHSA reserves the right to disregard such designations if they have been applied indiscriminately to non-protected information, and in no

event shall CalMHSA, its agents, representatives, consultants, directors, or officers be liable to a responding party for the intentional or inadvertent disclosure of all or a portion of a proposal submitted under this RFP, regardless of whether it was marked as confidential or trade secret.

Although the California Public Records Act allows certain confidential or trade secret information to be protected from disclosure, CalMHSA may not be in a position to establish that the information submitted is protected. If CalMHSA receives a request for public disclosure of all or any portion of a proposal that has been designated as exempt from disclosure, CalMHSA will use reasonable efforts to notify the responding party of the request and give such party an opportunity to assert, at its own expense, a claimed exception under the California Public Records Act or other applicable law within the time period specified in the notice issued by CalMHSA and allowed under the California Public Records Act.

Format of Proposal

Proposals must be submitted through CalMHSA's e-Procurement Portal at: https://CalMHSA.bonfirehub.com/.

Internet Explorer 11, Microsoft Edge, Google Chrome, or Mozilla Firefox. Javascript must be enabled. Submissions by other methods will not be accepted.
Browser cookies must be enabled. Respondents should contact Bonfire at Support@GoBonfire.com for technical questions related to submissions or visit Bonfire's help forum at:
https://bonfirehub.zendesk.com/hc.

Submission materials should be prepared in the file formats listed under Requested Information for this opportunity in the Bonfire Portal. The maximum upload file size is 1000 MB. Documents should not be embedded within uploaded files, as the embedded files will not be accessible or evaluated.

Submission documents must be in 12-point font in Times New Roman, single spaced. Exhibits

included herein by reference:

Exhibit 1	Cost Worksheet
Exhibit 2	CalMHSA 2020 Conflict of Interest
Exhibit 3	Proposal Submittal Letter

Appendix B. Vendor (CredibleMind) Scope of Work

Statement of Work - Monterey / LA

VENDOR: CredibleMind
WORK FOR: Monterey County / LA County
PROJECT TITLE: Help@Hand Screening Application

Schedule:
Start Date: August 2, 2021 Completion Date: May 31, 2023

Description of Project and Subcontractor Services:
To better meet the increased demand for services, MCBH and LACDMH have proposed the development of a comprehensive web-based mental health screening application that can screen for a broad spectrum of mental health disorders and refer individuals to the appropriate level of care within the local mental health services system.

CredibleMind, Inc. will develop an evidence-based screening application comprising a series of questions that provide the user with screening application results in a variety of mental health categories. Following the screening, the type and severity of mental health symptoms will be identified along with Help@Hand CalMHSA, Monterey County and Los Angeles County 7 corresponding treatment program options that best fit their needs. The application will be developed around the core criteria of:

- Easily accessible to individuals 18-years and older seeking mental health services as well as family members or friends supporting an individual experiencing symptoms of a mental health disorder
- Being able to screen for a broad range of disorders, from low risk with mild need to severe with urgent need.
- Lead to possible condition identification in the following seven areas (at minimum): a. Depression b. Bipolar Disorder c. Schizophrenia d. Psychosis e. PTSD f. Anxiety Disorders g. Substance abuse disorders
- Provides education on symptoms, associated risks, treatment options, and local resource information and whenever possible, and if desired by CalMHSA, high-quality self-help resources as determined by CredibleMind's credibility algorithm to individuals as well as family and friends supporting an individual
- Screening application results are easily accessible for use by community-based providers to help individuals acquire treatment.
- Maintaining confidentiality standards.
- Working fluidly in Spanish. Build upon current evidence-based screening tools with proven validity and utilize item-response theory to minimize the number of questions and time involved in the screening application.

Subcontractor will provide CalMHSA with the following Services and/or Deliverables:

Services	Key Deliverables (be descriptive)
Resourcing	Provide a dedicated team supplemented with advisors and consultants who are already engaged with CredibleMind or who have agreed to join the team for this project. Resources will include experts in psychiatry and psychology, user interface design, research, evaluation, and technology as outlined in the vendor proposal, making this project, CredibleMind's top priority.
1.0 Project Plan & Schedule ● Conduct Kick-Off Meeting with all project teams from CredibleMind and CalMHSA ● Meetings with each sub-group ● conducted ● Draft initial project plan ● Draft final project plan	Deliver project plan 4-weeks after signed contract: 1. Project kick-off meeting completed 2. Project plan and schedule initiated 3. Consultation with Technology team completed 4. Initial project plan and schedule completed pending required deliverables for Task 1.1
1.1 Develop a design-phase project schedule, work breakdown structure, resources, risk management plan, quality plan, change management plan, and project escalation path for the design phase of the project	1. Design-phase project schedule 2. Work breakdown structure 3. Resources 4. Risk management plan 5. Quality plan 6. Change management plan 7. Project escalation path for the Design phase Above will be delivered through the following milestones: 1. Initial project plan and schedule completed 2. Consultation with Technology team on additional plan components completed 3. Final project plan and schedule completed 4. Final project plan and schedule distributed and approved by CalMHSA
2.0 Research Plan	Deliver overall research plan inclusive of approach and timeline 4-6 weeks after project plan.
3.0 Conduct Research Conduct a literature review of original research to document the evidence base on mental health screening tools and studies of self-assessment tools by age and language groups, and comparing effectiveness of virtual with in-person, or other approaches and their associated costs	(Estimated to take 12-16 weeks) Comparative analysis of evidence-based self-assessment and screening tools (virtual, in-person, other) for children and adults in English and Spanish and their associated costs through the following milestones: 1. Requirement review meeting with CalMHSA 2. Scoping literature review completed 3. Final report of the literature review completed
3.1 Collaborate with expert psychiatrists and psychologists to identify existing screening tools on websites and through	List of evidence-based, non-proprietary, open-source clinical assessment and screening tools for outcomes of interest in English and Spanish with completion of the following milestones:

Google and Google Scholar search and identify the best practices for self-administered screening tools with good psychometric properties that are available in English and Spanish for target conditions in children and adults	1. Requirement review meeting with CalMHSA completed 2. Environmental scan/literature review completed 3. Final report and list of tools completed
3.2 Needs assessment, stakeholder interviews and potential patient and family member/friend focus groups in coordination with CalMHSA, and Monterey and LA Counties	Deliver analysis of interview responses which will address the following research goals: a. The perception of need from mental health and behavioral health agencies, the patients, and their family members/friends b. The barriers and facilitators to accessing mental health information, screening, and services c. The perception and community preferences of using technology for mental health screening and access from providers, patients, and their family members / friends. Cost considerations for implementation of various types of virtual screening tools Through completion on the following milestones: 1. Identified stakeholders for interviews and focus groups 2. Stakeholder interviews and focus groups completed 3. Interview report and needs assessment results delivered
3.3 Map the county behavioral health system through monitoring the county populations served and population trends, types of services offered, and key performance measures for behavioral health	List of key populations served and in need of services for each county, most common mental health conditions, existing services and associated costs for accessing mental health services, and key behavioral health performance measures through completion of the following milestones: 1. Requirement review meeting with CalMHSA completed 2. Mapping county behavioral health systems completed 3. Final report of behavioral health system maps for each screening application condition in each county instance
4.0 Functional Design Document Collaborate with the Technology Services Provider on design document	Within 12-weeks after research completed, provide a design document that outlines relationships between functionality and design requirements including workflows through the screening process and completion of the following milestones: 1. Design document initiated with Technology Services Provider 2. Design document completed
4.1 Create a draft of questions for the screening application using screening tools collected to conduct research and analysis. Remove any duplicated questions.	Deliver a version of the comprehensive web-based mental health screening application ready to be tested in the validation and evaluation components of the Design phase. Screening application will address the seven conditions listed in the project descriptions at a minimum and will include demographic questions that would branch to condition subtypes if relevant to the user as well as questions from validated, non-proprietary scales that assess social

	determinants of health, such as social support and neighborhood effects. Deliver draft of screening application questions though completion of the following milestones: 1. Draft of screening application questions completed in English and translated in Spanish 2. Internal user testing completed (in English and Spanish) 3. Internal QA testing completed
4.2 Conduct design sprints	Delivery of the following: 1. User personas 2. Onboarding prototype 3. Application prototype with questions and results 4. Prototype of ability for provider to access patient/user results Through completion of the following milestones: 1. User journeys developed 2. Usable application prototypes designed 3. User tests conducted 4. Application prototypes revised and approved
4.3 Conduct user testing to determine a range of time which the screening application is estimated to be completed by the user	Deliver user testing results to determine whether the screening application is extensive enough to deliver an effective outcome, but not so exhaustive that users fail to complete it due to an excessively lengthy process. Completion of the following milestones: 1. User testing script completed in English and translated in Spanish 2. Participants for user testing recruited (English and Spanish speakers) 3. User testing sessions completed (2 rounds for English and 2 rounds for Spanish. Each language will include 2-3 user testing sessions per round) 4. User testing findings summarized
4.4 Based on user testing results, refine screening application as needed and finalize a version to use for training materials	Final estimation of time it would take an end-user to complete the screening application (to be within 10-25min) through completion of the following milestones: 1. Screening application refinement completed if necessary. 2. Estimated time to complete finalized and distributed
5.0 Testing Plan and Validation Create a validation plan for dissemination of screening application to Monterey and LA residents and staff	(Estimated to take 8-10 weeks) 1. Validation specification meetings completed 2. Validation plan completed 3. Validation plan approved 4. Validation plan distributed 5. Validation on most recent supported versions of all major browsers (Microsoft Edge, Chrome, Firefox and Safari)
5.1 Conduct a validation study with user testing in Monterey and LA Counties	Provide a validation plan and validation study results and recommendations based on the completion of the following: 1. Recruit participants of various age groups, educational backgrounds, and various racial and ethnic groups, also making sure to include native Spanish speakers

	2. Validation kick-off meeting completed for requirement gathering 3. Validation study plan delivered and approved 4. Validation study completed 5. Validation report completed (including recommended revisions)
6.0 Training Materials: Create, Test and Distribute Create training materials for the cohort of CalMHSA, County staff and community-based providers for use of the screening application, test the materials in the field, revise based on feedback and distribute as needed	(Estimated to take 6-8-weeks) Deliver training materials for CalMHSA, County staff and community-based service providers 1. Draft training documents 2. Pilot training validation report 3. Final training documentation 4. Final training validation report Through completion of the following: 1. Initial training materials completed 2. Initial pilot training conducted 3. Final training conducted 4. Training materials updated based on validation and feedback 5. Electronic and printed training materials distributed
Distribute the screening application for initial piloting and use during training validation phase	Provide distribution plan and report through completion of the following: 1. Distribution plan approved 2. Distribution of screening application initiated 3. Distribution of screening application completed
7.0 Application Development	Develop and deliver mental health screening application inclusive of iterative updates and enhancements based on feedback and validation studies.
8.0 Technical Documents ● Create and update themes and features ● Write user stories and acceptance criteria per feature ● Confirm and elaborate user workflows from mockups ● Create technical design ● Create data design ● Document app/system architecture ● Document ERD ● Access and output compliant with HIPAA, PHI, PII and other modern security standards including being compliant with FedRAMP Medium standards to include a third-	(Within an estimated 6-weeks) Provide the following 1. Business Requirements Document 2. Functional Design Document 3. Technical Design Document 4. Application/System Architecture Document 5. Entity Relationship Diagram (ERD) 6. Application Workflow 7. Data Dictionary Through completion of 1. Mockups approved 2. Business Requirements Document approved 3. Functional Design Document approved (in collaboration with the Design team) 4. Technical Design Documents approved

party assessment of the security standards to ensure compliance with these standards	
9.0 Application Landscape / Environments ● Configure environments ● Setup test accounts ● Setup test environment security ● Configure environment monitoring ● Configure Sentry Error Logging ● Configure analytics	(Within an estimated 3-weeks) Deliver configured environments and access instructions through completion of the following: 1. Deliver test and production environments 2. Deliver access instructions
10.0 Application Prototype ● Review design ready user stories and size level of effort ● Choose release sprint targets ● Plan development sprint by scheduling user stories and assigning to developers ● Develop features and assign to QA ● Perform QA and assign to Product for UAT a. Perform UAT and schedule for Sprint Demo b. Conduct Sprint Retrospective c. Repeat sprints until application complete	(Within an estimated 16-weeks) Complete Continuous Application Deployment to Development and Staging as new builds and functionality is completed Functional and Technical Design Documents (updated as needed) through completion of the following steps: 1. Initial development sprint tasks defined 2. Critical mass of MVP Features Approved 3. MVP Released 4. Features pass unit testing and QA testing 5. Features pass UAT 6. Stakeholder Platform Functionality Acceptance
11.0 Test Strategy, Ongoing UAT and QA ● Resolve automated issue detection ● Confirm browser and versions for QA ● Conduct User Acceptance testing ● Conduct Functional Testing and Technical Testing ● Conduct Integration Testing (if needed) ● Triage QA Product issues in regular meetings ● Conduct Regression Testing	(Within an estimated 22-weeks) Provide: 1. Unit testing reporting definition 2. QA Triage Process definition 3. Functional Testing Document and test scripts 4. Technical testing document and test scripts 5. User Acceptance testing document and test scripts 6. Integration testing document (if needed) 7. Regression testing document (if needed) 8. Automated monitoring endpoints Through completion of the following steps: 1. Development Sprint QA Ready state achieved 2. Functionality QA Ready state achieved 3. Production deploy QA Ready state achieved

• Implement automated monitoring	
12.0 IT Training Strategy and Documents • Identify any outside IT responsibilities and document • Identify internal Site Configuration responsibilities and document • Identify any DevOps responsibilities and document	(Estimated to take 6-8 weeks in conjunction with 6.0 Training Materials) Once training materials are approved, provide: 1. IT Training Documents by component 2. IT Training Videos (if helpful for explaining) 3. Zoom or in-person trainings (as needed)
13.0 Production Deployment Setup subdomains	(Within 30-days of completing IT training strategy and documents) Provide LA County Instance, Monterey County Instance and necessary Staging Instances. Confirm county instances are accessible.
14.0 Post Go-live Support (Persists 180 days post go-live) • Engage with additional Project Management for post-deployment if necessary • Establish feedback and roadmap request channels • Establish issue resolution process • Regular check-in meetings	• Assign Project Manager (if different than previous Project Managers for post-deployment) • Provide forms for submitting change requests • Schedule regular meetings
15.0 Data Extracts (Persists 180 days post go-live) • Define final reports from technical documentation • Define reporting roles (e.g. which people receive and/or access which reports) • Create data extracts • Create email reports • Support for business intelligence and analytical tools Support for administration of the application (i.e. user access control, define user roles, security, maintain lookup tables, etc.)	Project Manager to establish reporting deliverable process per county and pilot site Deliver Data extracts and sample reporting for each county and pilot site Provide consolidated cross-county reporting option for CalMHSA Reports will be continually accessible to CalMHSA, County and Vendor for evaluation purposes.
16.0 Status Reporting (Persists 180 days post go-live)	Through approved privacy policy and outcomes dashboard, provide the following:

• Review Privacy Policy for conformity to disclosures of PII • Review PII Reporting methods per updated Privacy Policy • Create outcome dashboard • Update Quarterly Deliverables Report with Trend • Update Annual Deliverables Report with Trend	1. Mechanism for stakeholders to obtain accounting of disclosures of PII 2. Outcome dashboard* 3. Quarterly Status of Deliverables report* 4. Annual Status of Deliverables report* *These items will be maintained and reviewed on an ongoing basis.
17.0 Software Maintenance and Hosting	Provide ongoing development and support of the screening application
17.1 Development Software	Maintain licensing required for tools/applications used to develop the screening application
17.2 Production Software	Provide ongoing maintenance and required updates for compatibility and/or regulatory requirements
17.3 Annual Hosting Service	Manage and maintain hosting environment for production and testing environments
18.0 County Implementation and Operations	1. Setting up a county instance 2. Integrate county specific branding (or co-branding with CalMHSA/Help@Hand) 3. Integration of county specific behavioral health providers and services (including ability to get screening results to providers) 4. Raw data reporting to each county including data utilization and assessment results data (through interactive dashboard and/or data download) 5. Integration of county specific screening questions, messaging, and other links besides behavioral health services 6. Project manager — single point of contact for the implementation and operations 7. Self-service training tools (updated as the tool is used and improved) including documentation and videos
18.1 System Maintenance & Operations (M&O) • Project Manager schedules regular update meetings with county points of contact • Monitor systems and report issues • Monitor content quality • Monitor activities and report outliers	1. Transition to production 2. Steady state responsibilities assigned 3. Report of resolved performance issues 4. Report of resolved content issues 5. Report of resolved user activity outlier issues

19.0 Independent Evaluation and OAC Report CredibleMind will hire an Evaluation Team to conduct an independent outcomes evaluation of the screening application post-implementation in the pilot counties	(Estimated to take 6-8 months) Provide overall evaluation plan, evaluation results and recommendations based on completion of the following: 1. Evaluation kick-off meeting completed for requirement gathering 2. Evaluation plan delivered and approved 3. Evaluation completed 4. Evaluation report completed (including recommended revisions) Evaluation Team will deliver results from the following activities to both the CredibleMind and Help@Hand teams: a. 12-15 key informant interviews (e.g., clinicians, staff/management) b. 3-4 community focus groups (e.g., patients/families) c. County administrative/clinical records d. Patient data/records e. Patient in-take/surveys f. Documentary materials (e.g., project reports, meeting minutes)
19.1 Collaborate with the Evaluation Team to conduct process evaluation to establish a baseline evaluation and identify potential cost-effective and improvement areas via provider interviews and community member focus groups.	Evaluation Team will deliver results from the following activities to both the CredibleMind and Help@Hand teams: a. 8-10 key informant interviews from providers are more seasoned and work regularly with county screenings regularly from program/delivery level to administrative/executive level b. 2-4 community member focus groups (at least 1 in English and 1 in Spanish) to learn and understand patient/user experiences and perspectives Results will include a summary of current behavioral health system practices and delivery of mental health screenings in Monterey and LA Counties and will inform activities and objectives in 19.0 Evaluation.
19.2 Conduct an outcome evaluation of the application to assess efficiency and accuracy of referral connections, in collaboration with a cohort of County staff, community-based service providers, and other key informants	Provide outcome evaluation plan and outcome evaluation results and recommendations based on completion of the following: 1. Outcome evaluation kick-off meeting completed for requirement gathering 2. Outcome evaluation plan delivered and approved 3. Outcome evaluation completed 4. Outcome evaluation report completed (including recommended revisions)
19.3 Conduct an economic evaluation to assess the cost associated with self-assessments pre-post implementation of the mental health screening application and comparing cost of existing in-person screening to the	Provide an economic evaluation plan, economic evaluation results and recommendations based on the following: 1. Economic evaluation kick-off meeting completed for requirement gathering 2. Economic evaluation plan delivered and approved 3. Economic evaluation completed 4. Economic evaluation report completed (including recommended revisions)

virtual approach of the screening application	
19.4 Conduct general functionality and ease-of-use study through web analytics, web-based self-administered surveys, community focus groups and user testing with those using the application to determine usefulness of application for connecting targeted audience to resources	Provide a functionality and ease-of-use study plan, functionality and ease-of-use study results and recommendations based on the following: 1. Functionality and ease-of-use study kick-off meeting completed for requirement gathering 2. Functionality and ease-of-use study plan delivered and approved 3. Functionality and ease-of-use study completed 4. Functionality and ease-of-use study report completed (including recommended revisions)
19.5 Conduct impact evaluation of application with participating agencies/clinics as well as a cohort of community members	Provide impact evaluation plan, impact evaluation results and recommendations based on the following: 1. Impact evaluation kick-off meeting completed for requirement gathering 2. Impact evaluation plan delivered and approved 3. Impact evaluation completed 4. Impact evaluation report completed (including recommended revisions)
19.6 Work collaboratively with CalMHSA, Monterey and LA Counties to modify and refine the mental health screening application after input has been received	Provide refinement plan in collaboration with CalMHSA, Monterey and LA Counties based on completion of the following: 1. Refinement kick-off meeting completed for requirement gathering 2. Participation in and facilitation of refinement plan initiated 3. Participation in and facilitation of refinement plan initiated completed
19.7 OAC Report	Deliver final evaluation report meeting the following OAC requirements to CalMHSA and Counties no less than 6 months after previous deliverables Final evaluation results, including but not limited to: A. Description of the evaluation methodology B. Outcomes of the Innovative Project including those related to the selected primary purpose, with a focus on whatever was new or changed compared to established mental health practices C. Any variation in outcomes based on demographics of participants, if applicable D. Assessment of which activities or elements of the Innovative Project contributed to successful outcomes E. Explanation of how the evaluation was culturally competent F. Explanation of how stakeholders contributed to the evaluation. a. Whether and how the County will continue the Innovative Project, the source of ongoing funding, if applicable, the reason for the

	decision, and how the County involved stakeholders in the decision. b. Whether the Innovative Project achieved its intended outcomes and a summary of what was learned. c. Description of how the County disseminated the results of the Innovative Project to stakeholders, and if applicable to other counties (e.g. as the County determined that the information would be of benefit to other counties). d. Any other data or information the County considers relevant

For this Statement of Work, the following consumer/user data is the initial assumption of what will be provided by the vendor. Evaluation requirements may add additional data to be provided throughout the course of the project. Any additional data to be provided will be discussed with the Help@Hand team as the project progresses.

Data	Frequency
Demographic data such as age, gender, race, and ethnicity if provided	
Time it takes each user to complete the screening application	
Individual user responses from the screening application	
Responses leading to identification or severity, diagnosis, and referral	
Design validation study results for each county	Each round
Functionality and ease-of-use study data from web analytics, web-based self-administered surveys, focus groups and user testing - assess whether the screening application accurately gauges type and severity of mental illness - provides meaningful and accurate referral connections to the appropriate services or resources as efficiently as possible - determine whether the screening application reduces the hours and cost associated with in-person assessments - determine whether individuals (staff, community provider, peer, etc.) using this screening application to assist a user in need find the screening application useful for connecting that user to resources	
Impact evaluation - assess the overall impact the implementation of the screening application has on the total volume of patients entering services including its effects on the demographics of patients	

served	

CalMHSA Representatives:
Contract Representative: xxxx
Project Representative: xxxx

Appendix C: CredibleMind Research Plan

CredibleMind

October 2021

Help@Hand Screening Application Research Plan

1. Background

To inform the creation and development of the Help@Hand screening application, CredibleMind will conduct research into existing literature on mental health screening tools, engage with Monterey County staff and stakeholders, and map current resources and services in Monterey County Behavioral Health (MCBH) for at least seven proposed mental health conditions (outlined in 2. Goals).

As stated in the original request for proposal, "the primary problem being addressed by this project is the demand for mental health services outpacing the capacity of the mental health services system to appropriately screen and refer these individuals to treatment". In the case of MCBH, the demand for their gateway early intervention services, also known as ACCESS System of Care or simply ACCESS, has seen a 100% increase over a three-year period from FY2015-2017. The primary goal of this screening application is to reduce the burden on MCBH services.

This research plan provides an outline for the tasks and activities CredibleMind will undertake to fulfill research goals outlined in the statement of work. We recommend that this document be used to guide next steps, but may be subject to change depending on additional goals or questions that may surface throughout the research phase.

2. Goals

As stated in the statement of work, the goals for the research are as follows:

1. Document the evidence base on mental health screening tools and studies of self-assessment tools by age (16+) and language groups (English and Spanish)
2. Compare effectiveness of virtual tools with in-person or other approaches and their associated costs
3. Identify existing screening tools in English and Spanish for target mental health conditions
4. Identify the best practices for self-administered screening tools
5. Identify the best practices for validating a mental health screening tool or survey
6. Determine the perception of need from mental health and behavioral health agencies, the patients, and their personal support systems
7. Determine the barriers and facilitators to accessing mental health information, screening, referrals, and services
8. Determine perception and community preferences of using technology for mental health screening and access to services from providers, patients, and their family members/friends
9. Determine cost considerations for implementation of various types of virtual screening tools
10. Map the county behavioral health system through monitoring the county populations served and population trends, types of services offered, and key performance measures for behavioral health
11. Develop a final list of mental health conditions and other outcomes to include in screening application

Our initial research will focus on the following mental health conditions listed in the statement of work:

1. Anxiety disorders
2. Depression
3. Substance use disorders
4. PTSD
5. Bipolar disorder
6. Schizophrenia
7. Psychosis

Given that the majority of people who access MCBH services are MediCal recipients, or MediCal eligible, we will also consider including non-mental health condition outcomes such as social determinants of mental health (i.e. socioeconomic status, physical health, housing, transportation access and social support). There may be other mental health conditions that make sense to include for specific MCBH target audiences (i.e. ADHD for Transitional Age Youth populations).

3. Methodology

To better organize the research goals outlined above, there are three components to the research. Though each component will cover a specific set of goals, all three components will be informative in developing the final list of mental health conditions and outcomes (Goal 11).

A. Literature Reviews

A series of literature reviews will be conducted to assist with Goals 1-5. Here are the proposed steps for the "Review Component":

Step 1—Define the question.
Goals 1-5 can be further grouped into three main question themes:

a. *Evidence base on mental health screening tools and cost-effectiveness of virtual vs. in-person*
b. *Existing screening tools and best practices for self-administration for at least the 7 identified conditions as well as potential social determinants of health*
c. *Validation best practices and translation*

Step 2—Define the scope of review.
Scope includes: how many studies to review per question theme, how many years of studies to cover, age ranges and languages spoken by study population, studies with Medicaid/MediCal recipients, how many studies per condition/outcome

Step 3—Identify databases to search for literature.

Step 4—Conduct the review.

Step 5—Review and analyze the literature found.

Step 6—Synthesize and summarize findings for literature review reports.

B. Needs Assessment

A needs assessment will be conducted to assist with Goals 6-9. Depending on MCBH staff capacity and permission to survey current and/or former patients, we anticipate utilizing a mix of quantitative and qualitative methods such as interviews, focus groups, and surveys. Here are the proposed steps for the "Needs Assessment Component":

Step 1—Define the objectives and scope.

Including but not limited to experience with mental health screening, accessing services, finding information, the referral process, and technology preferences/accessibility

Step 2—Identify stakeholders/target populations.
May include H@H core team, ACCESS representatives, bilingual service providers, referral line operators, certain populations of potential users of the screening application (defining some typical user personas)

Step 3—Determine data collection methods.
Focus group and follow-up interviews/meetings with County professionals. Online and/or verbal questionnaires for clients and personal support systems

Step 4—Create prompts/script for interviewing and questionnaire.

Step 5—Schedule meetings and/or send questionnaires. Obtain informed consent and permission to record as needed.

Step 6—Conduct meetings and gather information. Record any verbal discussions.

Step 7—Synthesize and summarize findings for needs assessment report.

C. Behavioral Systems Mapping

Finally, we will conduct mapping of the resources and services within MCBH to assist with Goal 10. Here are the proposed steps for the "Mapping Component":

Step 1—Define scope of mapping.
Per SOW, will include information on general categories of populations served, most common mental health conditions, existing resources services, associated costs for accessing mental health services, and key behavioral health performance measures

Step 2—Identify sources for existing information.
May include co.monterey.ca.us web pages/documents, informational interviews with representatives from County departments, broader Help@Hand collected data, background information gathered while developing the RFP

Step 3—Conduct mapping.

Step 4—Synthesize, summarize, and visualize findings for mapping report.
Per SOW, we will encompass information for each screening application condition

4. Expected Results

At the conclusion of the research, we expect to deliver the following reports:

1. Results of literature review
2. List of screening tools for each condition/outcome
3. Results of needs assessment
4. Behavioral health system map of Monterey County including resources for each target condition/outcome

We also expect an early draft of questions for the screening application so we can begin testing the application internally in late 2021 or early 2022.

5. Timeline

The research will begin at the delivery of 2.0 Research Plan on October 12, 2021 and is expected to end at the delivery of 3.0 Conduct Research on February 3, 2022 for a span of about four months. Below is a detailed table of specific tasks and activities for each component and corresponding months.

Components	October 2021	November 2021	December 2021	January 2021	February 2021
Literature Reviews	Define research questions, scope of reviews Identify databases	Conduct review of literature Begin analysis of literature found	Continue analysis of literature	Continue analysis of literature Synthesize and summarize findings	Submit literature review reports
Needs Assessment	Define objectives and scope Identify stakeholders and target populations Determine data collection methods	Create prompts/scripts Schedule meetings and/or surveys	Conduct meetings and/or surveys Update prompts/scripts as necessary based on initial findings	Conduct meetings and/or surveys Synthesize and summarize findings	Submit needs assessment report
Behavioral Systems Mapping	Define objectives and scope Identify sources	Conduct mapping	Synthesize, summarize, and visualize findings	Submit systems mapping reports	

Appendix D: CredibleMind Research Report

CredibleMind

3.0 Research

MARCH 3, 2022

Introduction

The following pages include reports and required deliverables for 3.0 Conduct Research for the Help@Hand screening application project. Materials used to conduct the research tasks such as the environmental scan, literature review, needs assessment, and behavioral systems mapping are also included as appendices. All parts are listed in the Table of Contents below.

Table of Contents

Appendices (Not attached to this document)

1. Description of Process

From November 2021 to December 2021, the CredibleMind Research team conducted an environmental scan using Google, Google Scholar, PubMed, and PsycINFO. Search criteria included articles that referenced "mental health"; "screening" or "scale" or "survey"; any of the six base conditions i.e. "depression" and "anxiety" as well as search criteria related to specific research goals such as "Spanish", "Hispanic", or "Latin*"; "virtual" or "online" or "electronic" or "internet"; and "evidence".[1] The environmental scan was guided by two research goals deriving from the project's statement of work for this deliverable.[2] There was an additional research goal that guided the scan deriving from Deliverable 3.1 List of Scales.

1. Research Goal 1: Document the evidence base on mental health screening tools and studies of self-assessment tools by age (16+) and language groups (English and Spanish)
2. Research Goal 2: Compare effectiveness of virtual tools with in-person or other approaches and their associated costs
3. Deliverable 3.1 Research Goal: Identify the best practices for self-administered screening tools with good psychometric properties that are available in English and Spanish for target conditions in ages 16 and up.

Section 2. Literature Review Summary in this document summarizes findings for Research Goals 1 and 2. For the additional research goal to *identify best practices for self-administered screening tools*, please see "Section 3: Review: Best Practices for Self-Administered Screening Tools" in Deliverable 3.1 List of Scales (pp. 10-20). References are listed on pp 40-53.

2. Literature Review Summary

Research Goal 1: Document the evidence base on mental health screening tools and studies of self-assessment tools by age (16+) and language groups (English and Spanish)

Evidence Base on Mental Health Screening Tools

The evidence base on the use of mental health screening tools to determine next steps for an individual seeking care has been well studied and documented for various mental health conditions. Next steps for an individual could involve various types of interventions or treatments ranging from self-guided web-based interventions for lower risk patients to referrals to trained mental health professionals who may conduct diagnostic interviews or assessments for moderate to higher risk patients (Whitton et al., 2021). Compared to psychiatric examinations, screening tools tend to be more efficient, take less time, are more cost-effective, and can be less invasive for the person who is being screened (Eaton et al., 2007; Newman, 2004).

Screening Tools and Youth Populations

Though screening tools have been generally beneficial in mental health care, there are reported differences in effectiveness of screening between adult and youth populations. As a whole, there is a need for strong

[1] See Appendix A: Search terms and counts

[2] See Appendix B: Literature review comparison

psychometric tools that measure disordered eating, suicidality, psychosis, and substance use in youth and adolescent populations (Becker-Haimes et al., 2020; Beidas et al., 2015). Many screening tools were originally created and validated in adult populations and when applied to youth populations, researchers tended to create "downward extensions" (Becker-Haimes et al., 2020, p. 10) instead of brand new scales and surveys for youth populations. Though some original adult scales have strong internal consistency in youth populations, such as the PHQ-9, it is important to consider using youth-specific scales and surveys whenever possible to ensure strong internal validity, reliability, and consistency with youth (Becker-Haimes et al., 2020). Youth tends to be a target population for many mental health resources and interventions, and, with strong screening tools, early identification and intervention practices can be implemented. Such practices have been shown to be associated with better outcomes later in life (Kline et al., 2015).

Types of Screening Tools: Self-Administered vs. Clinician-Administered

There are different ways screening tools can be administered. They can be self-administered with the user completing the tool either in their own time or in the presence of a clinician or they can be clinician-administered. There have been several studies documenting the evidence of self-administered tools compared to traditional clinician-administered methods of screening (Ballester et al., 2019; Richter & Johnson, 2005; Whitton et al., 2021). Self-administered tools have been found to be effective and in "reasonable concordance" (Ballester et al., 2019, p. 2) with clinician-administered assessments. There are many advantages to using self-administered tools over clinician-administered tools. Self-administered tools are "easy to administer to large samples" (Richter & Johnson, 2005, p. 810) and can be administered at the same time in different settings. They tend to be more cost-efficient since they do not take up clinician time—in many studies, self-administered tools are offered in waiting rooms in clinical settings and the clinician can quickly make an assessment based on screening tool results (Whitton et al., 2021).

Evidence Base of Self-Administered Tools

Self-administered tools are effective to screen for common mental health conditions like depression, anxiety (Ballester et al., 2019; Beidas et al., 2015), and substance use (Richter & Johnson, 2005). In youth populations, self-reported screening for psychosis is helpful to assess early psychosis onset, even six months later, as well as to develop treatments that are more specialized and psychosis-oriented (Kline et al., 2015).

There is also evidence to support the use of self-administered screening tools to increase widespread access to mental health resources. For college students, widespread self-administered screening was associated with increased uptake with mental health services and allowed for more students to get referred to mental health care and counseling (Forbes et al., 2019).

One disadvantage to self-administered tools compared to clinician-administered is the likelihood of false positives. For certain concerns like suicidality, self-administered measures are often associated with high false positive rates (Bryan & Rudd, 2006), possibly due to the sensitive nature of the topic. Despite false positive rates, when tools are coupled with appropriate interventions, they may still lead to cost savings and be effective in preventing symptoms from getting worse (Dunlap et al., 2019; Forbes et al., 2019).

Another disadvantage to self-administered tools is that the link between using a self-administered tool and change in treatment rates or help-seeking behavior is uncertain (Haberer et al., 2013). For clinician-administered screenings, individuals are usually able to receive treatment and services within the same sitting whereas, for self-administered, if the individual is not completing the tool in a clinical setting, then there may be barriers to going and accessing care and services if they screen positively for symptoms. Some

studies have pointed to an increase in individuals accessing care (Forbes et al., 2019; Whitton et al., 2021) as well as help-seeking behavior when self-administered tools are used(Mirea et al., 2021; Jacobson et al., 2022) while others have actually found that self-administered screening tools may lower the desire to seek help from professionals (Batterham et al., 2016). At the minimum, self-administered tools can provide information in an accessible way (Emmelkamp, 2005).

Self-administered tools may also be useful for individuals who have never been screened for any mental health symptoms. Whitton et al. (2021) developed a web-based screening tool to screen for anxiety and depression symptoms for patients to use while they wait in waiting rooms of primary care clinics. With this new screening method, they were able to discover an unmet need in that 1 out of every 16 people screened had unidentified or untreated symptoms of depression or anxiety (Whitton et al., 2021).

Mental Health Screening in Spanish-Speaking Populations

Within the last couple of decades, there have been many studies on screening tools and self-administered screening tools, specifically, that are beneficial to use in Spanish-speaking populations (Arrieta et al., 2017; Ballester et al., 2019; García-Campayo et al., 2012; Mills et al., 2014; Muñoz-Navarro et al., 2017). Many self-administered tools have been validated in a Spanish-speaking population for anxiety (García-Campayo et al., 2010; Mills et al., 2014; Muñoz-Navarro et al., 2017), depression (Arrieta et al., 2017; Killian et al., 2021), and bipolar disorder (Sanchez-Moreno et al., 2008; Vázquez et al., 2010).

In conclusion, there is strong evidence for the use of mental health screening tools and self-administered screening tools. Screening tools can screen a large number of individuals quickly and self-administered tools are more cost-effective compared to clinician-administered or psychiatric examinations. The main disadvantage to self-administered screening tools is the likelihood of false positives. In addition, it is unclear whether self-administered screening tools have a great impact on help-seeking behavior or treatment rates, but research in this area is promising. The use of self-administered tools is not meant to fully replace the need for in-depth assessments performed by a trained mental health professional, but they can be the first step to receiving mental health information and accessing care in a quick and efficient way.

Research Goal 2: Compare effectiveness of virtual tools with in-person or other approaches and their associated costs

Technology use in mental health care has increased over the past few decades (Marks, 1999). Strengths of using technology in mental health care include increased "accessibility, reduced costs…flexibility…inter-activity, and consumer engagement" (Lal & Adair, 2014, p. 26). Technology has been used to administer screenings instead of relying on paper-based tools and traditional in-person screening, which are often time-consuming (Lal & Adair, 2014). The advantages of virtual screening tools in particular have been well documented and include less social desirability bias (Buchanan, 2002; Marks, 1999; Richman et al., 1999), the ability to screen a large group of people quickly and efficiently (Ballester et al., 2019; Haberer et al., 2013; Newman, 2004; Wallace & Bendsten, 2014), cost-effectiveness (Emmelkamp, 2005), and reduced stigma (Emmelkamp, 2005).

Social desirability bias is a type of response bias in which people may answer questions in a survey or scale in a way that they will be viewed more favorably by others (Krumpal, 2013). It is an important bias to consider with screening and can be used to explain rates of underreporting or overreporting. Compared to being screened by a clinician, virtual screening may make it easier for individuals to disclose sensitive

information (Buchanan, 2002) and offer individuals the opportunity to be more candid when completing tests online (Richman et al. 1999), especially in regards to screening for alcohol and other substance use (Marks, 1999).

Underreporting in substance use screening is often an issue when using traditional screening methods (Marks, 1999; Gryczynski et al., 2017; Marsch et al., 2020) and individuals may feel more comfortable reporting risky behavior to a computer or electronic device rather than to an actual person (Marks, 1999). In a systematic review of digital health use for substance use disorders, Marsch et al. (2020) found that certain virtual screening tools have comparable diagnostic characteristics with clinician-administered versions. Gryczynski et al. (2017) found a similar comparison but noted that virtual self-administered tools resulted in higher rates of reporting of past year alcohol, illicit drug, and prescription medication misuse. High rates of positive screenings are likely to be associated with higher rates of false positives so users should be encouraged to seek out a professional to confirm any positive screenings (Donker et al., 2009).

Virtual screening tools allow for the potential to reach a wider audience. Traditional mental healthcare involves primarily face-to-face interactions between the clinician and patient. These interactions tend to be synchronous and may mean that mental health screenings occur on an "irregular and infrequent basis, [possibly] reducing the potential effectiveness" (Haberer et al., 2013, p. 349) of these screenings. Virtual screening can occur asynchronously which allows more flexibility for the individual to screen themselves regularly and frequently without having to wait for the next visit (Haberer et al., 2013).

Along with reporting the benefits of virtual screening tools for mental health, researchers have also determined that virtual tools are as effective in determining risk as traditional screening methods, such as paper-based and clinician-administered screening (Ballester et al., 2019; Brøndbo et al., 2013; Mirea et al., 2021; Riva et al., 2003; van Ballegooijen et al., 2016). Virtual screening tools have been found to be in "reasonable concordance" with clinician-administered assessments and screening (Ballester et al., 2019, p. 2). Brøndbo et al. (2013) found agreement in diagnostic categories for 3 out of 4 patients between a clinician assigning a diagnosis from the results of a virtual screening tool compared to regular clinician assessment without the use of a virtual tool.

Alfonsson et al. (2014) conducted a systematic review to investigate differences in interformat reliability between virtual and pen-and-paper versions of mental health screening tools for various conditions. They reviewed 33 publications and assessed interformat reliability for 40 different symptom scales and found that the majority of instruments showed strong correlation between format scores (Alfonsson et al., 2014). These 40 self-report instruments covered the following areas: panic disorder, depression, anxiety, eating disorders, alcohol and tobacco dependence or misuse, obsessive compulsive disorder, post-traumatic stress, postpartum depression, social anxiety disorder, and insomnia (Alfonsson et al., 2014).

Virtual screenings have also been found to be useful and effective in pregnancy and childbirth settings. Mental health issues are notoriously underdetected and undertreated in perinatal settings (Kingston et al., 2015; Kingston, Austin, et al., 2017), but virtual screening can help reduce stigma and empower individuals to seek care. In a randomized control trial, pregnant women who were randomized into an virtual screening (e-screening) group favored the features of e-screening more than the control group who completed the screening using a traditional paper-based method (Kingston, Austin, et al., 2017).

Though many researchers claim that virtual tools are cost-effective compared to traditional methods, these studies have not provided numbers on actual or estimated dollars saved. Sin et al. (2020) conducted a systematic review of web-based interventions that provided screenings and also came to a similar conclusion—data on cost-effectiveness is particularly lacking.

Most of the published literature claiming that virtual tools are cost-effective have been based on assumptions and not cost-benefit analyses. Although the initial costs of researching and developing virtual tools are necessary, ongoing costs are assumed to be minimal after development due to less time spent by a clinician to administer the screening or review paper-based screening (Lal & Adair, 2014). Another assumption is that virtual screening may reduce costs due to early intervention and prevention practices. De Gara et al. (2008) claimed that investing in early detection screening methods can result in future cost reductions and duration of symptoms and disease. They developed a model to compare direct and indirect costs related to psychological screening. Direct costs include time spent on screening by professionals while indirect costs may include lost work days, decreased productivity, and forgone earnings of the individual being screened (de Gara et al., 2008). Online screening could increase early detection of symptoms or an active mental health condition since it is more readily available and accessible than in-person screening. Therefore, it's likely that being able to detect symptoms early before they worsen can help reduce therapy and treatment costs in the long-term (de Gara et al., 2008; Mirea et al., 2021). Early treatment can also influence indirect costs— undetected or untreated symptoms could worsen and affect a person's ability to work full-time or at all.

Despite the benefits of using virtual tools, there are many challenges facing successful implementation of virtual screening. As with any technology, privacy is a concern for many individuals and institutions (Haberer et al., 2013). Privacy measures have to be in place and tested to ensure that data is kept secure, even if the data is collected anonymously (Haberer et al., 2013). Another challenge is system and process changes within the current infrastructure. When converting screening from clinician-administered or paper-based to virtual, systematic changes need to be made to ensure efficient implementation. Current staff need to be trained and willing to adopt virtual screening into their current processes. Even if the tool is validated and shown to be effective, successful implementation is still dependent on widespread adoption (Haberer et al., 2013). Another challenge is limited access to certain groups. Although virtual tools may increase widespread access to mental health screening, there are still communities that will be left behind, as is the case with any technological innovation. Implementation may not be as successful for those living in remote or rural areas where internet access may be limited or for those who have limited proficiency in technology use, such as the elderly (Haberer et al., 2013).

Despite these challenges, the use of virtual tools for mental health screening is favorable as it can allow for " opportunities to improve access, quality, and sustainability of care for mentally challenged individuals in a system with limited resources" (Krausz et al., 2019, p. 139). More economic research is needed to determine estimated or actual cost savings for virtual screening tools compared to traditional methods.

3.1 List of Screening Tools

1. Description of Process

From November 2021 to December 2021, the CredibleMind Research team conducted an environmental scan using Google, Google Scholar, PubMed, and PsycINFO. Search criteria included articles that referenced "mental health"; "screening" or "scale" or "survey" or "measure*" or "assess*"; any of the six base conditions i.e. "depression" and "anxiety" as well as search criteria related to specific research goals such as "Spanish", "Hispanic", or "Latin*"; "virtual" or "online" or "electronic" or "internet"; and "self".[3]

From December 2021 to February 2022, members of our Clinical team were assigned to review scales based on their expertise and familiarity with the six baseline conditions. Anxiety and Depression scales were assigned to our clinical psychologist while Bipolar, Psychosis, Substance Use, and PTSD were assigned to our psychiatrists to review. The Clinical team was tasked to review each scale for its psychometric properties, study population, availability in Spanish, and other qualities.

In total, the Clinical team used fifteen qualities to compare scales within each condition category.[4] From this in-depth review, 17 scales were selected as candidates for use in the screening tool—this list is replicated below in Section 2: Recommended List of Screening Tools.[5] The recommended list of scales include scales that have strong psychometric properties (acceptable specificity, sensitivity, and Cronbach's alpha values), are brief (less than twenty questions), and have been validated in either a community setting or in a population that is generalizable to the screening tool's target population. Almost all of the scales are available in Spanish and have been validated in a Spanish-speaking population. Many of these have been administered as self-report or electronically.

For the purposes of the deliverable, the Research and Clinical teams have determined that the list of scales below are ideal to meet the needs of the research goals. Further discussions with the County will be necessary to determine the best scale (or two scales for two-stage screening) for each condition, County needs, and overall project goals.

2. Recommended List of Screening Tools

The CredibleMind Clinical team, along with the Research team, present the following list of evidence-based clinical assessment and screening tools for outcomes of interest in English and Spanish:

Scale name *(Citations)* *(Citations)*	**Condition(s) screened**	**# of items**	**Team notes**
4-item Patient Health Questionnaire (PHQ-4)	Anxiety Depression	4	We can ask remaining questions in the GAD-7 (for

[3] See Appendix A: Search terms and counts
[4] See Appendix C: Clinical screening tools comparison chart spreadsheet
[5] Table lists 15 scales and does not include separate rows for the GAD-7 or PHQ-9

(English: Kroenke et al., 2009) *(Spanish for the USA GAD-7)* *(Spanish for the USA PHQ-9)*			anxiety) or PHQ-9 (for depression) questions upon positive screening.
Washington Early Recognition Center Affectivity and Psychosis (WERCAP) *(English: Mamah, 2011)* ***No Spanish version found***	Bipolar Disorder Psychosis	16: 8 per condition	Ideal scale for Psychosis For Bipolar, we can start with WERCAP, then go onto BSDS or MDQ. For Bipolar, WERCAP is not as ideal as BSDS because questions read too extreme and may miss those with low manic states.
Bipolar Spectrum Diagnostic Scale (BSDS) *(English: Ghaemi et al., 2005)* *(Spanish: Vázquez et al., 2010)*	Bipolar Disorder	1-question story, then 18	Two-stage screener that begins with a story. If story resonates with user, then they can move onto the rest of the scale
Mood Disorders Questionnaire (MDQ) *(English: Hirschfield et al., 2000) (Spanish: Sanchez-Moreno et al., 2008)*	Bipolar Disorder	18	Has a parent version (P-MDQ) and adolescent version (A-MDQ)
Community Assessment of Psychic Experience (CAPE) *(English: Konings et al., 2006)* *(Spanish: Ros-Morente et al., 2011)*	Psychosis	15	Can use the shorter version (CAPE-15)
Self-screen-Prodrome (SPro) *(English: Kammerman et al., 2009)* ***No Spanish version found***	Psychosis	6	Not meant to be diagnostic so ideal for this project
Prodromal Questionnaire (PQ-16) *(English: Ising et al., 2012) (Spanish: Levey et al., 2018)*	Psychosis	16	Can help pick up on early symptoms as opposed to DSM diagnosis qualifiers only.
Primary Care PTSD screen (PC-PTSD-5) *(English: Prins et al., 2016) (Spanish PC-PTSD-5)*	PTSD	5	Two-stage screening model per VA standards. For the second stage, move onto PCL-5.
PTSD Checklist for DSM-V (PCL-5) *(English: Blevins et al., 2015) (Spanish PCL-C: Orlando & Marshall, 2002)* *(Spanish PCL-5)*	PTSD	20	The PCL-5 is the DSM-V version whereas the PCL-C is the DSM-IV version.

SBIRT pre-screen *English version* *Spanish version*	Substance Use	3	Standard two-stage model. For the second stage, move onto ASSIST, TAPS, or for specific substances,

			DAST-10 (drugs only) or USAUDIT-c (alcohol only)
Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) *(English: Group, 2002)* *(Spanish: Rubio Valladolid et al., 2014)*	Substance Use	1, then 7	Interview format that can be converted to a one question screener. Upon a positive screen, the user can move onto the remaining questions.
Tobacco, Alcohol, Prescription Drug, and Illicit Substance Use (TAPS) *(English: Wu et al., 2016)* *(Spanish: Sanchez et al., 2021)*	Substance Use	4, then 9	Two-stage screener with first four questions as the first stage. Upon a positive screen, the user can move on to the remaining questions.
10-item Drug Abuse Screening Test (DAST-10) *(English: Skinner, 1982)* *(Spanish: Bedregal et al., 2006)*	Substance Use (Drugs)	10	
USAUDIT-c *(English: Higgins-Biddle & Babor, 2018) (Spanish version)*	Substance Use (Alcohol)	3, then 7	Two-stage screener with first three questions as the first stage. Upon a positive screen, the user can move on to the remaining questions.
CRAFFT (Car, Relax, Alone, Forget, Friends, Trouble) Screening Instrument *(English: Knight et al., 1999)* *(Spanish version)*	Substance Use (Adolescents)	4, then 5	Recommend this separate screening for adolescents. Any substance use is considered high risk in terms of functional outcomes. There is a CRAFFT 2.1 and 2.1+N which also measures tobacco and nicotine use.

3. Review: Best Practices for Self-Administered Screening Tools

The second half of this deliverable was to identify the best practices for self-administered screening tools with good psychometric properties that are available in English and Spanish for target conditions in ages 16 and up. From November 2021 to December 2021, the CredibleMind Research team conducted an environmental scan using Google, Google Scholar, PubMed, and PsycINFO.[6,7] References are listed on pp 40-53.

[6] See Appendix A: Search terms and counts
[7] See Appendix B: Literature review comparison

Research Goal: Identify the best practices for self-administered screening tools with good psychometric properties that are available in English and Spanish for target conditions in ages 16 and up

Anxiety

Anxiety is one of the most commonly screened mental health conditions (Ballester et al., 2019; Beidas et al., 2015) and several tools have been developed to screen for anxiety symptoms. In 2011, Pilkonis et al. reported 145 different scales that measure anxiety. Anxiety measures used today tend to fall into two categories: generalized tools which measure common characteristics of various anxiety disorders and situation-specific tools which measure anxiety in response to specific events such as test anxiety, computer anxiety, or cancer anxiety (Rose & Devine, 2014).

To determine best practices for self-administered screening tools for anxiety, one of the main considerations to take into account is the target population. Generalized tools work well for larger sample sizes (Rose & Devine, 2014). Another consideration is content of interest (Rose & Devine, 2014). Since this tool is meant to be used for screening and not for diagnostic purposes, brief measures that screen for general anxiety and not specific types of anxiety such as agoraphobia are ideal. The Generalized Anxiety Disorder scale (GAD-7) (Spitzer et al., 2006) is an ideal scale to use in community or primary care settings—it is brief, can be self-administered, and has been used in virtual settings (García-Campayo et al., 2010; Plummer et al., 2016). The GAD-2 (Kroenke et al., 2007), the shorter version of the GAD-7, has also been found to be acceptable to use for identifying generalized anxiety symptoms (Plummer et al., 2016).

Anxiety in Spanish-speaking populations

The GAD-7 was originally translated and validated in Spanish with individuals seeking care and treatment for mental health conditions in Spain, half of which had a prior diagnosis of clinical generalized disorder anxiety and half of which did not (García-Campayo et al., 2010). Members of the same group of researchers also later validated the GAD-2 in primary care clinics in Spain (García-Campayo et al., 2012). The GAD-7 has since been validated in a group of Hispanic Americans with English or Spanish language preference recruited from a community sample (Mills et al., 2014). A computerized version of the GAD-7 has also been validated in primary care centers in Spain but researchers note high false-positive rates as a limitation (Muñoz-Navarro et al., 2017). They suggest other measures should be conducted to confirm a positive GAD-7 screening such as using a depression measure to determine the presence of generalized anxiety with comorbidities and/or having a clinician perform a clinical interview to confirm (Muñoz-Navarro et al., 2017).

Interestingly, Mills et al. (2014) found that the "Spanish language-preference group had higher GAD-7 total scores and greater variability in scores in comparison to the English language-preference group" (p. 7). However, after controlling for socioeconomic and demographic factors, they found no significant differences in GAD-7 scores between the language-preference groups (Mills et al., 2014). Despite the lack of statistical significance, it is still important to consider socioeconomic differences when measuring anxiety in Spanish language-preference groups. The immigrant experiences of Spanish language-preference groups are vastly different and may result in varying levels of worry and distress which could help explain the varying GAD-7 scores found between language-preference groups (Mills et al., 2014).

Depression

Depression is another of the most commonly screened mental health conditions (Ballester et al., 2019; Beidas et al., 2015) and has become a priority for screening in primary care settings due to high rates of

undetected cases (Houston et al., 2001). In 2009, the US Preventive Services Task Force released a recommendation statement to screen all adults when "staff-assisted depression care supports are in place and selective screening based on professional judgment and patient preferences when such support is not available" (Siu et al., 2016, p. 386). They updated this recommendation statement in 2016 to remove selective screening after recognizing these supports are "much more widely available and accepted as part of mental health care" (Siu et al., 2016, p. 386). In the 2016 update, they also recommend depression screening specifically in perinatal settings given the impact depression can have on the health and wellbeing of not only the pregnant person or new parent, but also their child (Siu et al., 2016).

Best practices for using self-administered screening tools for depression depend on the target population. The 9-item Patient Health Questionnaire (PHQ-9) (Kroenke et al., 2001) is a self-report tool that is brief and has been used widely (Reynolds & Patel, 2017). In general settings, it is recommended to also screen for anxiety because depression and anxiety frequently co-exist (Reynolds & Patel, 2017). For all populations, it is recommended to provide psychoeducation or access to therapy or counseling, especially when screening virtually (Buchanan, 2002). Mirea et al. (2021) found that including online psychoeducation with comprehensive mental health screening for individuals experiencing depression symptoms had a positive effect on the mental health of individuals searching for mental health information—65% of 1300 participants rated the psychoeducation component as useful. The implications of adding psychoeducation and therapy options to virtual screening results will be discussed in more detail in a later section.

The PHQ-2 (Kroenke et al., 2003), the shorter version of the PHQ-9, has been found to be a useful screening tool in many studies (Arroll et al., 2010; ; Levis et al., 2020; Manea et al., 2016). Many researchers recommend using a cut-off score of 2 or more rather than 3 or more to ensure that potential diagnoses are not missed (Arroll et al., 2010; Manea et al., 2016). However, a lower cut-off score is associated with lower specificity, resulting in the potential of higher false positive rates (Manea et al., 2016). For youth populations, some researchers found that a cut-off of 3 or more was ideal for maximizing sensitivity without a significant loss in specificity (Richardson et al., 2010) while others used a cut-off of 2 or more but still found the PHQ-9 to be superior in screening for depression in an adolescent population (Anand et al., 2021). To ensure accurate and quick screening, it is recommended to use the PHQ-2 followed by the PHQ-9 (Levis et a., 2020).

For perinatal populations, the detection and treatment of postpartum depression remains a high priority (Drake et al., 2014; Kingston et al., 2015; Kingston, Austin, et al., 2017). There is a lot of stigma associated with postpartum depression so many individuals may report very few or no symptoms to clinicians during screening (Kingston, Biringer, et al., 2017). Virtual methods of screening have been useful in providing an easy and more accessible way of being screened and destigmatizing discussing and seeking care for postpartum depression (Drake et al., 2014; Kingston, Austin, et al., 2017). One study that used technology to administer the Edinburgh Postnatal Depression Scale (EPDS) found this method to be reliable, valid, and in alignment with paper-based screening methods (Drake et al., 2014). Participants in another study reported the features of virtual screening more favorably than paper-based and preferred using a device to answer questions rather than paper-based (Kingston, Austin, et al., 2017).

Depression in Spanish-speaking populations

The PHQ-9 has been shown to be a valid measure for Latinx populations in the US for both English and Spanish-language preference groups (Huang et al., 2006). The PHQ-2 has also shown to be valid for use in Spanish-speaking populations (Arrieta et al., 2017). Despite strong validity, some researchers have reported poor internal reliability for the PHQ-9 for Latinx populations, especially for female-identifying groups. Killian

et al. (2021) found that "the single item related to fatigue had the greatest variation" (p. 8) across all race/ethnicity profiles. Particularly for the Latinx population, moderate symptoms could be categorized into two profiles: those with higher scores on questions related to somatization symptoms—feeling tired, having little energy, or sleeping too much and those with higher scores on questions related to negative self-view—feeling down or feeling bad about yourself (Killian et al., 2021). They recommend a follow-up clinical assessment be conducted "to tease out the burden of symptoms and personalize treatment accordingly" (Killian et al., 2021, p.9).

Bipolar disorder

Bipolar disorder is known to be underdetected in primary care settings (Carvalho et al., 2015; Zimmerman et al., 2011; Zimmerman, 2014). Several screening tools have been created to help increase routine screening for bipolar in primary care settings (Carvalho et al., 2014; Zimmerman et al., 2011) but many clinicians have encountered high false positive rates and misdiagnoses when using screening tools alone to detect bipolar disorder symptoms (Zimmerman, 2014).

Bipolar disorder symptoms are characterized by extreme highs (mania or hypomania) and lows (depression). Individuals with bipolar disorder are also more likely to experience symptoms of depression and anxiety; therefore, the overlap of depression symptoms plus higher likelihood of comorbidities have resulted in bipolar disorder being underdiagnosed often or misdiagnosed anxiety or depression disorders (Zimmerman, 2014)

The Bipolar Spectrum Diagnostic Scale (BSDS) (Nassir Ghaemi et al., 2005) and Mood Disorders Questionnaire (MDQ) (Hirschfield et al., 2000) are examples of bipolar self-administered screening tools that have been used in primary care settings. Carvalho et al. (2015) conducted a systematic review and meta-analysis of accuracy studies for bipolar screening and assessment tools including the BSDS and MDQ. They found that there were more studies supporting accuracy properties for the MDQ than the BSDS (Carvalho et al., 2015). BSDS had high sensitivity and specificity rates at a cut-off score of 12 in a population of individuals with major depressive disorder or bipolar disorder (Zimmerman, 2014). However, for the detection of bipolar II disorder, the MDQ is less satisfactory because of its poor specificity and high possibility of false positive rates (Zimmerman et al., 2011), possibly due to the potential for individuals to misrepresent or misremember hypomanic episodes and symptoms (Carvalho et al., 2015). Researchers recommend combining any positive screening with a follow-up assessment to confirm diagnostic criteria.

In younger populations, two versions of the MDQ were introduced by Wagner et al. (2016): a parent-version (P-MDQ) and an adolescent-version (A-MDQ). Youngstrom et al. (2005) conducted a study comparing the validity of screening for bipolar disorder between parent and adolescent versions of the MDQ and found the P-MDQ acceptable to use but not the A-MDQ. However, Miguez et al., (2013) found the A-MDQ to be acceptable for screening but because of high false positive rates, they recommend a follow-up assessment to confirm a positive screening.

The Washington Early Recognition Center Affectivity and Psychosis scale (WERCAP) (Mamah, 2011) was developed to detect both bipolar disorder and psychosis symptoms and has been validated in a youth sample (Mamah et al., 2014). Though some researchers have not found the WERCAP as useful to detect bipolar disorder symptoms due to the heterogeneity of symptoms and potential for confounders (Mamah et al., 2014), others have shown that the bipolar disorder section of the WERCAP had high sensitivity and specificity rates at an optimal cut-off score of more than 20 (Hsieh et al., 2016).

Another consideration to take into account when screening for bipolar disorder is that because borderline personality disorder (BPD) and bipolar disorder share similar symptoms, BPD is often misdiagnosed as bipolar disorder (Zimmerman et al., 2010). Especially when using the MDQ for screening, Zimmerman et al. (2010) found that BPD was four times more frequently diagnosed in positive MDQ screenings than negative MDQ screenings. Palmer et al. (2021) found that certain items in the MDQ were significant predictors of bipolar disorder and non-predictors of BPD so upon a positive screen, they suggest looking these particular items more closely.

For self-administered bipolar disorder screening, the best practice is to follow-up with a clinical diagnostic assessment or interview to confirm a positive screen as well as to rule out other mental health conditions such as borderline personality disorder.

Bipolar disorder in Spanish-speaking populations

The BSDS and MDQ have been translated and validated in Spanish-speaking populations (Sanchez-Moreno et al., 2008; Vázquez et al., 2010). When validating the Spanish version of the BSDS within a sample of psychiatry patients in the US, Vázquez et al. (2010) found that lowering the cut-off score from 13 to 12 increased the scale's sensitivity and slightly decreased the specificity. Sánchez de la Cruz et al. (2018) also found that a cut-off score of 12 was the most ideal for sensitivity and specificity within a sample of psychiatry patients in Mexico.

When validating the MDQ within a sample of psychiatry patients in Spain, Sanchez-Moreno et al. (2008) found a cut-off score of 7 or more hypomania symptoms showed the best balance of sensitivity and specificity for detecting bipolar disorder.

To date, the WERCAP has not been translated into Spanish or validated within a Spanish-speaking population, but it has been successfully translated into Kamba and validated within a community sample in Kenya (Ndetei et al., 2019)—therefore, successful translation, cross-cultural adaptation, and validation into other languages and non-English-speaking populations is promising.

Psychosis

Psychosis has typically been screened using clinician-administered tools or interview settings which can be time-intensive and difficult to scale in community settings (Addington et al., 2015; Kline & Schiffman, 2014). Kline & Schiffman (2014) conducted a systematic review and found 13 self-report measures used to identify "individuals at clinical high risk of psychosis" (p. 12) including the Community Assessment of Psychic Experiences (CAPE) (Konings et al., 2006) and the 16-item Prodromal Questionnaire (PQ-16) (Ising et al., 2012). They found a wide range of psychometric data based on study settings (Kline & Schiffman, 2014).

In an adolescent sample, Mossaheb et al. (2012) reported that a cut-off score of 3.2 for the CAPE had moderate sensitivity and specificity and lowering the cut-off to 2.8 increased the sensitivity but decreased the specificity and had higher rates of false positives. For the PQ-16, a cut-off score of 6 or more demonstrated good sensitivity and specificity values and lower rates of false positives (Ising et al., 2012). McDonald et al. (2019) studied the performance of an web-based version of the PQ-16 in the general population and also found that a cut-off score of 6 or more demonstrated good sensitivity and specificity values.

As mentioned in the **Bipolar disorder** section, the WERCAP can also be used for psychosis screening (Mamah, 2011). The WERCAP was found to perform well for psychosis screening, especially for estimating "overall psychosis severity" (Mamah et al., 2014, p. 1766). In a large longitudinal population-based study of adolescents and young adults, the WERCAP was also validated for psychosis screening with 3-month timeframes being the most predictive of meeting diagnostic criteria for psychosis (Mamah et al., 2022).

The Self-screen-Prodrome (SPro) (Kammerman et al., 2009) is another self-report psychosis screening that has been validated for use in the general population as a first step in an assessment or diagnostic process (Müller et al., 2010) as well as to distinguish symptoms between ADHD and psychosis (Corbisiero et al., 2017). In a systematic review, Addington et al. (2015) found that using a 6-item subscale, also known as SPro-Psy-Risk, was acceptable to distinguish between positive psychosis screenings from other psychiatric diagnoses.

For self-administered psychosis screening, the best practice is to follow-up with a clinical diagnostic assessment to confirm positive screenings. If possible, it is also recommended to ask individuals to answer questions with shorter time frames in mind, such as 3-months (Mamah et al., 2022).

Psychosis in Spanish-speaking populations

There is a literature gap regarding mental health service use for psychosis among Latinx populations—from what is available, researchers estimate low usage rates and low treatment rates (Casas et al., 2014). Low usage may derive from low screening rates or underdiagnosis of psychosis in Latinx communities (Mischoulon et al., 2005). Underdiagnosis may be prevalent among Spanish-speakers due to the low level of psychosis literacy (Casas et al., 2014) and differing manifestations of psychosis symptoms (Mischoulon et al., 2005). In a large epidemiological study that looked at racial and ethnic differences in the prevalence of psychosis symptoms, higher lifetime rates of psychosis symptoms were reported by Latinx than any other racial or ethnic group (Cohen & Marino, 2013). Despite higher prevalence of psychosis symptoms, only a small percentage of Latinx individuals meet diagnostic criteria for a psychosis disorder (Lewis-Fernández et al., 2009).

Routine psychosis screening in community settings is a high priority due to the association between risk of psychosis and risk of lifetime health condition or disability (Oh et al., 2018; Oh et al., 2019). In one study, Oh et al. (2019) found that the odds of reporting a lifetime health condition or disability was 1.75 times greater for those experiencing psychosis symptoms. In a previous study, Oh et al. (2018) found that the odds of reporting lifetime experiences of psychosis symptoms was about 1.5 to 3 times greater for individuals with disabilities. However, these epidemiological surveys grouped Black, Asian, and Latinx individuals together, so the literature gap on implications for psychosis screening in Latinx communities still persists.

Some scales have been translated into Spanish but limited validation studies in the general population or community settings exist. The Spanish version of the CAPE was found to have good consistency with the English version (Ros-Morente et al., 2011), but the only validation study to date was conducted among college students at a university in Spain (Fonseca-Pedrero et al., 2012). The PQ-16 has been translated into Spanish and validated for use within a pregnant population in Peru (Levey et al., 2018).

Neither the SPro nor the WERCAP has been translated into Spanish or validated within a Spanish-speaking population.

PTSD and Trauma

PTSD is also a commonly screened mental health condition (Lancaster et al., 2016). Screening for PTSD in a non-military, general population has become more widespread and several tools exist to allow for a quick identification of those at risk for PTSD based on their "exposure to a Criterion A traumatic event" (Lancaster et al., 2016, p. 3). In the DSM-V, Criterion A traumatic events include "actual or threatened death, serious injury, or sexual violence" (American Psychatric Association, 2013, pp. 271-272). On a higher level, exposure includes directly experiencing the event, witnessing it in-person, learning that the event happened to a close family member or friend, or experiencing repeated or extreme exposure to details of the event secondhand i.e. in the case of first responders (American Psychiatric Association, 2013). Trauma screening tools work well in busy settings such as primary care clinics (Lancaster et al., 2016). The Life Events Checklist is an example of a trauma-exposure screener that has been supported for use in the literature (Gray et al., 2004). There is now a DSM-V version, the LEC-5 (Weathers et al., 2013).

Trauma screening tools are often combined with PTSD symptom screeners (Lancaster et al., 2016). Both the Primary Care PTSD Screen (PC-PTSD) (Prins et al., 2004) and PTSD Checklist-Civilian Version (PCL-C) (Blanchard et al., 1996) are used widely to screen for PTSD (Freedy et al., 2010; Lancaster et al., 2016). In a study comparing several PTSD screening tools, Freedy et al. (2010) found that both the PC-PTSD and PCL-C performed well and showed adequate sensitivity and specificity—they preferred the PC-PTSD for its briefness.

The US Department of Veteran Affairs (n.d.) recommends a two-stage screening process for PTSD that begins with the PC-PTSD-5 (Prins et al., 2016), the DSM-V version of the PC-PTSD. For the second stage, they recommend a structured interview but also suggest using a validated self-report measure if an interview is not possible. Specifically, the PCL-5 (Blevins et al., 2015), the DSM-V version of the PCL-C, was mentioned as having strong psychometric properties (US Department of Veteran Affairs, n.d.). This two-stage screening process of using the PC-PTSD-5 first and then the PCL-5 has also been found to be acceptable for use in youth populations (Nadeem et al., 2021).

PTSD and Trauma in Spanish-speaking populations

There are many historical, cultural, and social considerations that need to be taken into account when screening for PTSD and Trauma in Latinx populations. These include immigration status, country of origin, current family structure, current community connection, spirituality and religion, and language (Fierros & Smith, 2006; Fortuna, n.d.). There are also certain terms that some Spanish-speakers use to describe feelings of distress. Also known as "culture-bound syndromes" (Fortuna, n.d, p.3), knowing and including these terms in screening tools or clinical assessments may help contextualize certain symptoms. For example, *ataque de nervios* is often brought up as a symptom or experience in Latinx populations and includes "uncontrollable screaming or shouting, crying, trembling, sensations of heat rising in the chest and head, dissociative experiences, and verbal or physical aggression" (Fortuna, n.d., p. 3).

The PC-PTSD-5 has been translated into Spanish but it is unknown who did the original translation and it is also unclear whether this version has been validated. A virtual version of the DSM-IV PC-PTSD worked well among Spanish-speakers in a community health center (Ahmad, 2017).

The DSM-IV version of the PCL-C has been translated into Spanish but the original translation study did not find the Spanish version fully equivalent to the English version based on differential item functioning parameters (Orlando & Marshall, 2002). Despite the lack of full equivalency, Orlando & Marshall (2002) still

find it acceptable to use for general screening. Miles et al. (2008) revealed that the inconsistent equivalency discovered in the original Orlando & Marshall (2002) study was not significant, deeming the two versions equivalent (Miles et al., 2008). The Spanish PCL-C has since been validated within a pregnant population in Peru (Gelaye et al., 2017). The PCL-5 has been translated into Spanish. It is uncertain who did the translation or if the translated version has been validated, but the Spanish PCL-5 has been used in at least three studies (Carmona Camacho et al., 2021; Sangrà, et al., 2021; Sobregrau Sangrà et al., 2022).

Substance use

For substance use screening, the SBIRT or Screening, Brief Intervention, and Referral to Treatment model is a validated, comprehensive public health approach that has been implemented in a variety of settings (SAMHSA, n.d.). Self-administered and virtual screening methods have been found to work well for measuring substance use—since substance use is heavily stigmatized, users may feel more comfortable disclosing substance use via self-administered or virtual options (McNeeley et al., 2018; Richter & Johnson, 2001; Wallace & Bendsten, 2014). Therefore virtual screening can be a useful approach during implementation of the first step of the SBIRT model.

One thing to consider when using virtual tools for substance use screening is to have a clear statement for participants that their information and data will be kept confidential (McNeely et al., 2018; Wallace & Bendsten, 2014). Alcohol use especially tends to be underreported in traditional screening methods, possibly due to social desirability bias (Richter & Johnson, 2001) or stigma and perceived consequences of disclosing substance use (McNeeley et al., 2018).

Similar to PTSD screening, substance use screening also follows a two-stage model. In the first stage, a scale or one-question pre-screener is completed to determine which substance(s) might be at risk of misuse, if any (Saitz et al., 2014). For the second stage, specific questions about the substances are primarily asked in the context of dependence, risk, or if there have been any health, social, legal, or financial problems as a result of substance use. Examples of second-stage screeners include the Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) (Group, 2002), the Tobacco, Alcohol, Prescription Drug, and Illicit Substance Use (TAPS) tool (Wu et al., 2016), the 10-item Drug Abuse Screening Test (DAST-10) (Skinner, 1982), the Alcohol Use Disorders Identification Test (AUDIT) (Saunders et al., 1993), and for youth populations, the CRAFFT screening instrument (Knight et al., 1999).

The ASSIST 2.0, the briefer version of the ASSIST, is clinician-administered and acceptable to use in primary care settings—it measures 10 substances: tobacco, alcohol, cannabis, cocaine, amphetamine-type stimulants (ATS), inhalants, sedatives, hallucinogens, opioids, and 'other drugs' (Group, 2002). A validation study determined that the ASSIST is able to "discriminate between low, moderate, and high risk substance use…[especially] for alcohol, cannabis, ATS, opioid, and cocaine use" (Humeniuk et al., 2008, p. 7). The ASSISTc, a computer-based version of the ASSIST, has been validated in a sample of university students in Brazil and found to be comparable to the interview version (Christoff et al., 2016). Barreto et al. (2014) adapted the ASSIST to use as a self-administered version and validated it in a sample of university students in Brazil. They found this version to be acceptable for use and comparable to the interview version though correlation scores between the self-administered version and interview version for cocaine, ATS, sedatives, inhalants, and hallucinogens were poor (Barreto et al., 2014).

The TAPS tool is a two-stage screening and brief assessment tool and measures all commonly used substances (Wu et al., 2016). As a response to the ASSIST, it was developed to take less time and is validated

for self-administration (Wu et al., 2016). The first stage, the TAPS-1, is used for screening and asks about frequency of use of tobacco, alcohol, illicit drugs, and nonmedical use of prescription medications (Wu et al., 2016). The second stage, the TAPS-2, further assesses the use of positively screened substances and also provides a risk level (Wu et al., 2016). The TAPS tool has been shown to be acceptable to use via self-administered and virtual screening approaches and the TAPS-1 can be administered as a standalone screener (Adam et al., 2019; McNeely et al., 2016; Wu et al., 2016). One thing to note in a study that used virtual TAPS screening is that the addition of audio guidance proved to be an important feature (Adam et al., 2019). Adam et al. (2019) found that 18% of participants used audio guidance—those who used this feature were more likely to have lower education, be older than 65, and were either Latinx or Black. Therefore if an audio option is not feasible, researchers recommend some variation of interview-administration to ensure the tool is accessible for as many people as possible (Adam et al., 2019).

The DAST-10 screens for drug use only and has been validated for use in a variety of populations and settings (Yudko et al., 2007). It has also been validated for use as a self-administered tool in primary care settings (McNeeley et al., 2021) and has been used for virtual screening (Talih et al., 2018). However, some studies have reported that a one-question screener is as effective at identifying drug misuse as the DAST-10 (Hearon et al., 2015; Smith et al., 2010).

The USAUDIT-c screens for alcohol use only and is a more accurate version of the AUDIT because of its briefer screening capability and adaptation to standard drink sizes found in the US (Higgins-Biddle & Babor, 2018). The USAUDIT-c is a two-stage screener where users are asked three questions about their alcohol consumption and upon positive screening, are asked an additional seven. It has been validated for use as a self-administered tool in primary care settings (McNeeley et al., 2021) and as a virtual tool to screen for at-risk drinking (Villarosa-Hurlocker et al., 2020).

The CRAFFT screening tool was developed specifically to screen for substance use among adolescents and stands for: Car, Relax, Alone, Forget, Family/Friends, and Trouble (Knight et al., 1999). There is an interview version and a self-administered version and the self-administered version is preferred (Boston's Children Hospital, n.d.). A virtual self-administered version of the CRAFFT has been validated for use in primary care settings (Harris et al., 2016). Some researchers suggest altering the yes/no binary response format to assess for frequency of use to improve sensitivity as yes/no questions tend to have a greater likelihood of underreporting (Harris et al., 2016). Others suggest modifying the Car item to account for groups that may be less likely to be in cars in order to reduce disparities in sensitivity rates among different racial ethnic groups and socioeconomic statuses (Lee et al., 2021). There are two additional versions of the CRAFFT: the CRAFFT 2.1 has higher sensitivity than its predecessor and also includes vaping and the CRAFFT 2.1+N has extra questions related to tobacco and nicotine use (Boston Children's Hospital, n.d.).

Substance use in Spanish-speaking populations

Many substance use screening tools have been translated into Spanish and validated within Spanish-speaking populations (Bedregal et al., 2006; García Carretero et al., 2016; Pérez Gómez & Díaz-Granados, 2011; Rubio Valladolid et al., 2014; Sanchez et al., 2021).

The Spanish version of the ASSIST has been validated in primary care settings and specialized addiction treatment centers in Spain (Rubio Valladolid et al., 2014). Lopez-Rodriguez & Rubio Valladolid (2018) validated a virtual version of the ASSIST that was accessed online and available to the general public. They found this method worked well for estimating prevalence of at-risk substance misuse (Lopez-Rodriguez & Rubio Valladolid, 2018). McNeely et al. (2014) converted the ASSIST into an audio guided computer assisted self interview format and found it to be feasible and acceptable to use in Latinx populations.

The TAPS tool has been translated and found to be feasible to use within a Latinx sample in a US-based primary care setting (Sanchez et al., 2021) but has not yet been validated. The DAST-10 has been translated and validated within a Latinx population in the US (Bedregal et al., 2006). Researchers reported using a cut-off score of 4 to identify drug misuse had stable psychometric properties (Bedregal et al., 2006).

The original AUDIT has been translated into Spanish and validated within a sample in Spain (Contel et al., 1999). THe AUDIT-C, which are the first three questions of the AUDIT, has been translated into Spanish and validated within a university setting in Spain (García Carretero et al., 2016). The USAUDIT-c has been translated into Spanish but has not yet been validated.

The CRAFFT has been translated into Spanish and validated within a sample of adolescents in Colombia (Pérez Gómez & Díaz-Granados, 2011), Argentina (Bertini et al., 2015), and Spain (Rial et al., 2019). In all three settings, the CRAFFT had adequate to strong psychometric properties and was shown to be acceptable for use in screening adolescents for substance use. The CRAFFT has been validated for use in Latinx populations in the US, but studies were done in English using the English version (Lee et al., 2021). Both the CRAFFT 2.1 and CRAFFT 2.1+N have been translated into Spanish (Boston Children's Hospital, n.d.).

Suicidality considerations

In the PHQ-9, item 9 reflects suicidality and thoughts of self-harm: *Thoughts that you would be better off dead, or thoughts of hurting yourself in some way?* (Kroenke et al., 2001). Some researchers have addressed considerations for suicidality based on this item (Jacobson et al., 2022; Whitton et al., 2021).

In general, suicidality is a highly sensitive topic and may be tricky to include in an online screening tool. Jacobson et al. (2022) found that although online screening tools may influence help-seeking behavior, "referrals to in-person treatments could put individuals at a greater risk of active suicidal intent" (p. 276). However, most of the time, these referrals were static links and not dynamically presented with clear calls-to-action (Jacobson et al., 2022). Without proper calls-to-action, they theorized that the referral initiation process may have been overwhelming for some people and did not feel encouraged to follow through (Jacobson et al., 2022).

In Whitton et al. (2021)'s study of a virtual screening tool, a score of 1 or more on item 9 was flagged to the primary care provider (PCP) in a separate area in the patients' screening results. PCPs were provided with various ways to support patients whose screening was flagged "including providing prompts to help initiate a discussion with the patient regarding their responses on the screener, steps for further assessing risk, information describing how to develop a safety plan for patients who are actively suicidal, and links to relevant local and national crisis services" (Whitton et al., 2021, p. 2021).

Benefits of psychoeducation

Adding psychoeducation to virtual screening reports has been shown to be beneficial in perinatal settings (Kingston et al., 2015) and in primary care settings (Whitton et al., 2021). In perinatal settings, participants were more likely to engage in screening if they knew that there were explanations behind why sensitive questions were being asked as well as self-help around emotional struggles (Kingston et al., 2015). In a primary care setting, two-thirds of the participants who were prescribed self-guided web-based interventions reported using the intervention initiality, although researchers did not determine rates of ongoing engagement (Whitton et al., 2021). The other web-based option was guided therapy. Interestingly, out of both web-based interventions, the majority of people who were prescribed to web-based self-help used it while only about half of people who were prescribed to guided web-based therapy reported using it. It is unclear how many participants were prescribed to both types of interventions so preference of self-help over guided therapy is unknown (Whitton et al., 2021).

Final considerations

For youth populations, there is a need for strong psychometric tools that measure disordered eating, suicidality, psychosis, and substance use (Becker-Haimes et al., 2020; Beidas et al., 2015) that are specifically built and tailored to this age group, rather than "downward extensions of adult measures" (Becker-Haimes et al., 2020, p. 10). Positive screening in these areas in youth populations should be followed-up with a clinical assessment to confirm a positive screen.

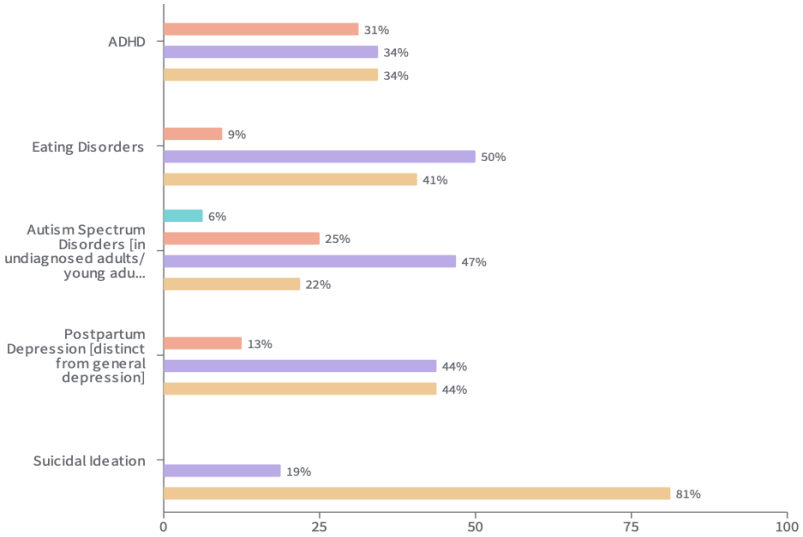
When implementing self-administered screening, some researchers discuss concerns that a universal screening approach would lead to an increase in referrals (Forbes et al., 2019). Forbes et al. (2019) enlisted the help of graduate students to help reduce demands on campus mental health professionals. Kingston, Austin, et al. (2017) argue that having virtual screening can reallocate "scarce human resources to where they are most needed—in-depth follow-up assessment, referral, and treatment" (para. 6) and Krausz et al. (2018) argue a similar case.

One way to limit referrals is through decision theory. Smits et al. (2007) conducted a study that examined how decision theory can be used to determine optimal cut-off scores for different groups. Even though validated screeners usually already have cut-off points that determine severity of risk (i.e. low, moderate, high), optimal cut-off points may be different for different circumstances. For health service providers, false positives can result in increased costs since positive screeners would require in-depth assessments (Smits et al., 2007). Therefore, cut-off points may be altered to ensure that the amount of potential false positives does not create a huge burden of cost on the system.

Finally, for additional best practices for self-administered screeners for a Spanish-speaking population, Aponte-Riviera et al. (2015) argue that creating clinics and health centers specifically dedicated to serving Latinx populations can help target the issue of underrepresentation in research studies. They also suggest that "an understanding of cultural variables, the recruitment of bilingual and bicultural staff, and the development of partnerships with community agencies are essential" (Aponte-Riviera et al., 2015, p. 5).

4. Considerations and Questions for MCBH

Several considerations and questions were raised from focus group and interview participants, the literature review, and the Clinical team. The first part of this section outlines content considerations for seven additional conditions to include in the screening tool. All seven were mentioned by focus group and interview participants. The



needs assessment survey (N=93) also included a question about other conditions to include in the tool in which MCBH professionals were asked to *Please rate how important you think it is to include each additional item* (left). If the County decides to include screening for one or more of these additional conditions, the team would determine the best scale or survey to use during the Development phase of the screening tool. The second part outlines specific questions we have for the County, all of which would affect the development of the tool.

A. Pregnancy and parenting–related depression

Based on findings from the needs assessment, we are recommending to include screening for pregnancy and parenting-related depression using the Edinburgh Postnatal Depression Scale. We would include a screening question to determine pregnancy or childbirth status. For example: *Are you currently pregnant or have you been pregnant within the past two years?* If the user responds *Yes*, then they would see questions for this particular scale. If *No*, then they would see questions related to general depression.

B. Suicidality and self–harm

Several focus group and interview participants advocated for including a measure or question to assess for suicidality or self-harm risk. There are ethical as well as technological implications to consider if the County ultimately chooses to include screening for these sensitive topics. We have outlined three scenarios:

Scenario 1—**Don't ask at all**. If a scale includes a question asking about suicidality or risk of self-harm, then we could remove the question. For example, the PHQ-9 asks a user to determine how often they had "thoughts that [they] would be better off dead or of hurting [themselves] in some way" (PHQ-9 source). In this scenario, we would remove this question though there are still opportunities to display relevant resources. In a user's results page, there can be a section with resources under *What to do if you are experiencing thoughts of self-harm* that can be triggered if the user's results indicate high risk or concern for depression or trauma. In the general resources page, relevant resources can be added for anyone to access.

Scenario 2—**Assess for a non-specific level of risk and provide information to relevant resources**. If the County decides to include screening for suicidality and self-harm, then we could include the above question in the PHQ-9 or add a similar question that assesses a non-specific level of risk. Since the question asks about "thoughts" of suicide or self-harm, a level of risk cannot be determined as opposed to if the question asked about intent or a plan. If a user responds to this question anymore than the minimum response, than their results would automatically display the suicide hotline number, suicide prevention information, and other related resources.

Scenario 3—**Assess for level of urgency and help stratify risk.** If the County decides to include screening for suicidality and self-harm and would want to ask questions to determine any level of need or risk, then this warrants a plan for an immediate safety response. An immediate safety response would entail someone monitoring screening

tool results regularly and being able to follow-up via call or text if a user's results triggered a safety response. Because we recommend not requiring users to provide contact information, we do not recommend Scenario 3.

C. Trauma

Some participants advocated for including trauma screening in addition to PTSD screening as not all trauma qualifies for a PTSD diagnosis. There are options to screen for traumatic life events using a scale such as the Life Events Checklist for DSM-5 (LEC-5) or Adverse Childhood Experiences (ACEs) Questionnaire for traumatic events that occurred during childhood.

D. Eating disorders

Some participants advocated for screening for eating disorders, especially since 16 is the minimum targeted age of the screening tool. We are aware that there are very few local resources and services for eating disorders in Monterey County, but CredibleMind would be able to provide self-help resources for users who meet the threshold to see these resources.

E. General mental distress

A few participants advocated for screening for general mental distress in place of screening for each individual condition. We recommend that a general mental distress scale be added in addition to screening for individual conditions. There may be situations where users do not meet cut-off criteria for a specific condition but screen positively for some mental distress and would still benefit from being referred to self-help resources or local resources. The World Health Organization's Five Well-Being Index (WHO-5) is an example of a good brief general mental distress scale.

F. Social determinants of health

Several participants advocated for screening for social determinants of health (SDoH)—mainly, transportation access was cited as a huge barrier for clients and insurance status was cited as primary criterion to determine a client's referral pathway. There are validated measures that assess for various SDoH factors such as food security and housing that can be included or we can have a general checklist of factors and ask people to designate which factors they may need assistance with. If the County chooses to include screening for SDoH factors, then the Development team would collaborate with United Way in order to link to the 211 system and/or the Smart Referral Network software.

G. Questions for MCBH

This section outlines questions we have for MCBH that will help to inform the development of this screening tool.

- **How should we approach screening for suicidality or self-harm risk?** See Section B: Suicidality and Self-Harm for more information.
- **How should we approach crisis or at-risk situations in general?** If a user scores severely in any condition, we plan to display hotlines, text lines, etc. in their results. Does the County have specific recommendations or things they would want to see in a results page for a user who is "in crisis"?
- **From the Clinical team: Should we include screening for Behavioral Addictions? What about Borderline Personality Disorder?** Some substance use scales and surveys that screen for alcohol and drug misuse also include screening for behavioral addictions (i.e. gambling, video game addiction, sex addiction). Is this

important to the County to include? In addition, we are contracted to screen for bipolar disorder which is commonly misdiagnosed as borderline personality disorder (BPD) and vice versa as both conditions share symptoms (Zimmerman et al., 2010). Does the County want to include screening for BPD?

- **How "close" should we get to a diagnosis?** Based on the needs assessment, many providers gave feedback that this tool should not be diagnostic. Though we will not tell users directly that they have a diagnosis, some of the scales we are considering including can assess whether a person is at risk or not and if at risk, assess further if they meet diagnostic criteria. For many scales, users only need to respond to the first few questions and depending on their score, they can continue on to the rest of the scale (i.e. a positive screen) or stop (i.e. a negative screen). For the screening tool, if a user screens positively we can 1) continue displaying the rest of the questions for that condition to get "closer" to diagnostic criteria or 2) stop at the point of a positive screen. Regardless if the screening tool determines that they may meet diagnostic criteria, users will still be referred to ACCESS and other resources.
- **Other than SDoH, what other information does MCBH need to know from clients?** Based on the needs assessment, we recommend asking about transportation and insurance status. We also recommend asking about age, gender, and language preference which are standard demographic questions to ask in comprehensive screening tools. What other information is MCBH interested in? Examples include physical health or medical status, employment, or previous or current history within ACCESS/MCBH.

1. Description of Process

From October 2021 to November 2021, the CredibleMind Research team developed focus group and interview protocols[8] as well as a survey[9] to disseminate to individuals in Monterey County for the needs assessment.

Focus groups and interviews: We conducted a pilot focus group with 3 individuals on November 19, 2021 to test the protocol. Afterward, we engaged with our MCBH contacts to recruit additional participants. Recruiting continued from December 2021 to February 2022—our MCBH contacts spearheaded connecting us with potential participants and forwarding contact information to the Research team for follow-up.

In a four-month span, we conducted 7 focus groups (including the pilot) and 3 interviews with a total of 29 participants. Participants ranged from ACCESS providers, MCBH staff, professionals from community agencies, and general community members. All participants provided informed consent prior to the focus group or interview session.[10] All focus groups and interviews were conducted via Zoom in English. Participants were shown a brief slide deck describing the project and key stakeholders.[11] Eight participants were community members (not representing a professional agency) and each was compensated with a $40 gift card for their participation. We also developed a brief optional survey for participants to complete after the session in case they wanted to submit feedback or comments anonymously but did not receive any feedback that added to our prior knowledge base. Please see 2. Summary of Findings below for more details on the outcomes of the focus groups and interviews.

Survey: Along with the qualitative methods mentioned previously, the Research team developed a survey for people who live or work in Monterey County to augment the needs assessment with quantitative data. The survey was created via a website called Survey Sparrow and two pathways were developed: one for MCBH professionals and one for community members. The community member version was translated into Spanish by a native Spanish speaker. The survey officially launched on January 20, 2022 and closed on February 28, 2022. We offered an incentive for community members by promoting a drawing to win one of fifteen $50 gift cards upon completion of the survey in order to increase participation.

We initially marketed the survey by emailing it to a list of email addresses of 240 Monterey County professionals and community members. We also reached out to former focus group and interview participants as well as other local organizations and agencies, such as public libraries and Monterey County United Way, and asked them to share the survey with their constituents. MCBH posted our survey marketing and promotion materials on their social media platforms.[12] In total, we received 93 responses, 32 who indicated they currently work for MCBH and 61 who did not. Please see 2.0 Summary of Findings for more details on the survey.

[8] See Appendix D: Focus group and interview protocols
[9] See Appendix E: Copy of final survey
[10] See Appendix F: Informed consent letter
[11] See Appendix G: Slide deck for focus groups
[12] See Appendix H: Survey marketing materials

2. Summary of Findings

Below is a summary of findings based on the three research goals outlined in the statement of work. For focus groups and interviews, we had 29 participants total: 16 MCBH professionals, 8 community members, and 5 professionals representing other community agencies that provide mental health support or sometimes interact with MCBH. For the survey, we received 93 responses: 32 who selected *Yes, I am an MCBH employee or work for MCBH"*and were directed to questions in the MCBH professional pathway and 61 who selected *No, I am not an MCBH employee nor do I work for MCBH* and were directed to questions in the community member pathway. Survey results can be found in Appendix I. Most of the information in this section are considerations expressed by Monterey County community members and professionals and gathered from focus groups, interviews, and the survey. Some information was retrieved from an internal draft of results from EVALCORP's annual MCBH needs assessment which MCBH contacts provided to CredibleMind and other information was retrieved from MCBH's FY 2020/2021 Data-Driven Decisions (D3) report which is publicly available (Monterey County Behavioral Health, 2021).

Goal 1: The perception of need from mental health and behavioral health agencies, the patients, and their family members/friends

Meeting the diverse needs of Monterey's diverse community

- When asked if the triage/intake process is able to meet the diverse cultural needs and preferences of the Monterey County community, 30% of surveyed MCBH staff disagreed
- When asked about the availability of culturally aligned and language accessible resources, 42% of surveyed MCBH staff reported that it "needs some improvement" and 11% reported "needs significant improvement"
- Both professionals and community members expressed a need for more Spanish- speaking providers as well as greater capacity for providing services and information in indigenous Mexican languages such as Triqui, Zapoteco, and Mixteco. These sentiments echo the findings within MCBH's own annual needs assessment.
- Services that are welcoming and uplifting of LGBTQIA2+ community members are limited. It's difficult to determine if services are accepting of all sexual/gender identities.

A young adult focus group participant related:

"I have a lot of intersections—intersecting identities with my gender, my sexuality, my Hispanic background, and just certain experiences that I went through. If I don't have a professional who's like, I don't know, Spanish-speaking or who understands where I'm coming from culturally, or have some training in like the LGBT community, I don't feel as comfortable because I feel like I have to put up a face."

Clearer and more transparent communication around the service-seeking process

- 55% of surveyed MCBH staff felt that clients did not have appropriate expectations or understanding of the triage and intake process.
- ACCESS representatives shared that triage and intake appointments

sometimes last very long because people believe they are beginning therapy during the initial consultation.
- Community members reflect on not being told or not understanding that they may have to talk to more than one person before beginning treatment with a clinician. They also lacked information on expected timelines and expectations of the role they played in their own treatment. Many individuals expressed confusion about whether they themselves or the staff member working with them was responsible for reaching out to referred services, initiating scheduling, or similar tasks.

More services for specific populations

- The underserved populations that were most frequently mentioned include people seeking treatment for disordered eating, people seeking help in South County, and individuals without health insurance who had less than severe mental health concerns.
- When asked about availability of resources for most needs, 42% of surveyed MCBH clinicians responded "needs significant improvement" and an additional 37% responded "needs some improvement".
- In terms of screening and assessment specifically, parents want more tools to be able to identify mental health challenges in their children. People have noticed more mental health challenges in their children since the onset of the pandemic. Barriers such as lack of transportation, lack of time, stigma, and lack of mental health services at schools make it more difficult for parents/caregivers to effectively procure help and information.
- MCBH recently completed their annual needs assessment in which they surveyed 276 providers and 200 community members. 85% of providers indicated that "services were available to communities and regions they served, but were insufficient to meet the need" (Monterey County Behavioral Health, 2022). In general, they reported that:
    - 66% of providers indicated this insufficiency specifically for low-income individuals
    - 65% for individuals exposed to trauma
    - 64% for individuals experiencing homelessness
    - 62% for individuals who primarily speak Spanish

Improved coordination and continuity of care

- When asked if they can easily and reliably share necessary client information with providers outside of their organization or department, 20% of surveyed MCBH staff strongly disagreed and 45% disagreed.
- Community members who participated in the focus groups expressed a range of related concerns. Some felt like they had to "start from scratch" with each new provider they were referred to and felt frustrated by answering similar questions multiple times. Others felt blindsided by the information that was passed between providers and desired more opportunities to give consent and improved communication around information that is shared.
- Improved systems of sharing information within and between agencies is

necessary to improve the screening/triage, assessment, and referral processes for both clients and providers.

Goal 2: The barriers and facilitators to accessing mental health information, screening, and services

Barriers

Lack of providers

As is the trend nationally, the demand for mental health providers exceeds the supply in most areas. Community members recount times where they had to wait six months or longer to begin receiving the services they were primarily referred for. Particularly for people who are reluctant to seek mental health support in the first place, this can be a major deterrent to continuing care and an exacerbating factor to their current mental health. MCBH staff who completed the survey advised that more resources should be given towards staff retention efforts.

Though the expansion of telehealth has increased access to care, many people still express a preference for being seen in person. As mentioned in the previous section, geographical areas such as South County have a dearth of mental health providers. Clients are sometimes unable to access services due to lack of transportation and/or lack of services in proximity to their residence.

As also mentioned above, another barrier to care is lack of culturally representative clinicians. Community members feel that it is very important to receive services from people who speak their language and can relate to their background and life experiences.

Lastly, many people are unable to access mental health services during normal business hours. Providers who are able to see clients in the evening or the weekends would increase accessibility.

Lack of information on available services

- Aside from certain areas of need, there are many mental health resources in Monterey County but professionals and community members expressed having difficulty staying aware of what services exist—48% of surveyed MCBH staff said that their familiarity with available resources or their ability to access a directory of resources "needs some improvement" or "needs significant improvement" and 69% felt that it is difficult to get accurate up-to-date information on community resources. During a focus group, one community member expressed:

  "I know that for emergency, I go to CHOMP. But if I have a collapse, for example, mental collapse or mental breakdown, where should I go? What can I do? "

Besides a general internet search, United Way 211 and a resource guide called SAM's Guide (McNelley, n.d.) were the primary directories utilized to identify mental health resources. Many MCBH staff said that they often create their own resource lists.

MCBH received similar concerns on their annual needs assessment:

> *"Participants stated that the lack of knowledge about where to get help was a key barrier along with cost, long wait lists, and the locations of services being far. They expressed that program staff were working to meet the needs of those they served, but they lacked the knowledge of where to send individuals who needed different services than their specific program provided. Participants suggested that providers be more educated about services in the area and that awareness be raised by using flyers, teachers informing students, and a community liaison or hot line. They also suggested having an online site to go to that shows the services provided and insurance types accepted"* (EVALCORP, 2022).

Stigma and misinformation

Though society is generally becoming more welcoming of discussing and addressing mental health needs, many people in Monterey County identify stigma as a primary barrier to seeking help and accessing care. Community members' ideas around mitigating stigma and misconceptions included:

- Culturally relevant messaging in various languages (via social media and Whatsapp in particular)
- Receiving information from within the community—people want to hear from people who look like them and have similar backgrounds. Videos of either community members talking about their experiences receiving support in Monterey County or of Peer Support Professionals (similar to the Vida Community Health Worker Program) help people feel more willing to receive the information
- Enlisting organizations like Centro Binacional para el Desarrollo Indígena Oaxaqueño (CBDIO) to develop mental health material in indigenous Mexican languages
- Promoting anonymous ways of obtaining support and information (such as the online screening tool being developed in this current project)
- A guide or program called "Introduction to Mental Health in Monterey County" could be used to educate new employees across various sectors. Public school educators, in particular, could receive training on how to recognize mental health symptoms in their students and refer them to the appropriate outlets.
- In some unique scenarios, individuals have expressed fear that seeking mental health support will have negative legal repercussions such as in cases of intimate partner violence or immigration.

Unclear eligibility requirements

In the survey results, 58% of MCBH staff expressed difficulty ensuring that clients are eligible for services they might refer them to and 73% of MCBH staff said that clients' ability to get in contact and register with referred services "needs significant improvement" or "needs some improvement".

Though MCBH's "No Wrong Door" practices appear to have a positive impact on the accessibility of mental health services, community members still express feeling uncertainty about where they should seek care based on what they are experiencing, their insurance status, financial capacity, and other factors. They also expressed feeling frustrated when being referred away from their initial point of contact. For example,

ACCESS providers have to call referral organizations to confirm their availability and eligibility requirements since this information fluctuates frequently. This sometimes increases the amount of time clients have to wait to begin treatment or requires them to switch providers.

Facilitators

Increased availability of virtual appointments

Community members appreciate being able to receive care virtually since it offsets any transportation/location barriers. It also saves people time and money as they do not have to leave their job or find childcare in order to take an appointment

ACCESS professionals describe how virtual appointments allow certain segments of the population to be reached more easily. Conversely, some clients demonstrate decreased motivation or engagement when meeting virtually—there can be hindering technical difficulties or there can be more back and forth when trying to schedule appointments.

"No Wrong Door" practices

County mental health providers are working hard to not turn away anyone who is seeking services regardless of that person's initial entry point to the system. At ACCESS locations, anyone who calls or presents to a clinic seeking support will at least receive some information on where they can obtain help even if they may not be eligible for services with MCBH directly.

Interpretation services and bilingual practitioners

Though there is a need for more language accessibility, many people expressed appreciation and satisfaction in their ability to access care in their preferred language.

Information sharing between providers

In cases when there are accessible ways to share information between two providers and it's done in a timely manner, this leads to positive outcomes for both the client and the providers.

Monterey County United Way 211 and Smart Referral Network (SRN)

Both providers and community members utilize 211 to identify local resources that match their needs. The 211 SRN system, in particular, maintains up-to-date information on all involved providers and implements a bidirectional referral process. This means that providers in the SRN system are able to follow up with clients on whether they were able to access services and provide support throughout that process. Currently, the referral process conducted through ACCESS/MCBH is not a bidirectional process.

Goal 3: The perception and community preferences of using technology for mental health screening and access from providers, patients, and their family members/friends. Cost considerations for implementation of various types of virtual screening tools

Access to technology

Monterey County residents that participated in CredibleMind's needs assessment expressed concern for the potentially large swaths of the population who lack internet access via phone and/or computer. School and library computers were common points of internet access mentioned by community members as well as using free wi-fi hotspots at places like fast food restaurants.

Comfort with using technology

Those who may have internet access may not be comfortable with using technology for a variety of reasons. Certain portions of the population are more likely to have low digital literacy such as older generations and

certain subgroups within the migrant communities. Some people are often wary of receiving or providing information on the internet since it can be difficult to gauge the trustworthiness of a particular site and know how one's personal information is being used.

Accessibility

Since some level of reading is required to navigate most technology, there are concerns around people who lack reading literacy. Having audio buttons that read on-screen text out loud can be supportive in these cases. One way that technology increases accessibility is that access to it is not barred by time or location. People can utilize online resources on their own time and transportation would not be a barrier. The immediacy of access to information the internet can provide is also beneficial at times.

Privacy preferences

The anonymity of the internet may make it easier for people to seek support for things that they may not feel comfortable doing publicly. As previously mentioned, stigma is a major barrier to mental health services which makes digital services an important option and opportunity. People with social anxiety and younger generations may also find the internet a more accessible space.

Technology may allow individuals to initiate care at their own pace. For some people, finding preliminary information or self-help resources online can be a less jarring way to begin their mental health journey as opposed to starting off by talking to a clinician directly.

Additional considerations for online mental health screening

Though many people expressed numerous benefits of technology, many of the same people also shared that they prefer human connection when it comes to mental health care. A lengthy online screening has an even greater risk of losing people's engagement and motivation. The sensitive nature of mental health topics also presents a risk when people may be confronted with difficult themes while in a distressed state. It will be important to be intentional about the language used in an online screening and to inform people how to get immediate support if needed.

- In more severe cases, such as people who demonstrate high risk for behavior that would harm themselves or others, there are qualms around how such situations would be addressed to not only ensure safety but also protect people's privacy and right to consent.
- Another unique population subset that may struggle with online mental health screening is people experiencing schizophrenia or other types of psychosis. There may be more paranoia around using an online screener especially since it asks direct questions about mental health.

Aggregate data from screening results could provide some insight into the population-level mental health of the County. It is important to consider, though, that 1) people have a tendency to underscore or under-report when answering questions about themselves and 2) a self-screener is not a diagnostic tool.

On an individual level, online mental health screening can boost autonomy by providing people with language and context with which to discuss their mental health concerns. One young adult focus group participant felt that an online assessment could be a self-advocacy tool in times where they perceive that a provider is downplaying their concerns.

Sharing online mental health screening results with a provider can also help cut down on time spent on

triage and can provide supplementary information to a person's health record. With this preliminary information, providers can begin to gauge probable severity/acuity and be able to address a client with a more trauma-informed approach. An MCBH supervisor suggested that clients and providers have access to the same format of results so that clients do not feel blindsided by any information shared.

Mental health professionals that we spoke with expressed a desire to be able to track whether a person used or accessed any resources recommended to them upon completion of online mental health screening. Community members also discussed wanting the option to receive follow-up after taking a self-screening.

Cost considerations for implementation of various types of virtual screening tools

The initial cost considerations for implementing a virtual screening tool is research and development of the product. For this current project, CredibleMind was contracted at a total cost of about $810,000 to research and develop the tool. Once the tool is created, the ensuing costs include implementing the tool in the County ($30,000-$60,000 depending on population size), training staff on utilization of the tool (~$51,000), post-go live support (~$48,000), and ongoing maintenance and support of hosting the platform post-launch ($8,000 per year). Since the virtual tool is intended to be a self-screener, staff training would mainly involve orienting people to the content of the tool and instructing them how to use any sharing capabilities such as viewing a client's screening results or adding results to client charts. The complexity of staff training will depend on what features and functionality are agreed upon during the development phase.

An additional cost consideration is keeping referral resources up to date, whether that is on CredibleMind, in which the cost would be for the assignment of an official account manager or on MCBH, in which the cost would be related to staff time to review and update resources on a regular basis.

Aside from the initial implementation fee of $30,000 and ongoing hosting costs of $8,000 per year, additional costs for MCBH and ACCESS post-launch are difficult to predict. MCBH's goal of implementing an online screening tool is to mitigate the increased burden on mental health providers as more and more people are seeking services. A self-screening and referral tool can help divert individuals from ACCESS if they may be better supported receiving care from a different provider, but there is also the possibility that more people will seek out ACCESS services. This tool will likely increase awareness of ACCESS services as an available resource and cause more people to consider seeking mental health support for the first time. Based on numbers in MCBH's FY 2020-2021 D3 report, "assessment/evaluation" services make up 13% of total services but take up 26% of the total service minutes. "Linkage/brokerage" services make up 31% of total services but take up 25% of the total service minutes. A virtual screening tool can help shift resources away from these two areas so that providers can spend more time providing direct treatment.

Efforts to increase utilization of the tool creates another additional cost consideration. Our discussions with professionals and community members raised suggestions such as:

- Providing tablets or creating kiosks in ACCESS clinics where people who lack internet access or digital literacy can take the tool
- Training peer support workers who can promote the tool in the community and also aid people with completing the tool in-person at ACCESS clinics
- Developing widespread marketing efforts in community places where people gather such as the hospitals, library, and laundromats

For community members, the singular cost consideration surrounds having access to a device and sufficient

data/wi-fi to complete a virtual screening tool.

Suggestions on the features and functionality of the current screening and referral tool project offered by CredibleMind survey respondents

- "Spanish marketing! A bigger Facebook presence in Spanish-speaking communities. Perhaps reaching out to Spanish local trusted agencies like church & radio stations "
- "Emphasize that treatment is available from providers other than psychiatrists and psychologists (licensed social workers, marriage and family therapists, Papillon Grief Services, etc) that are much less expensive than traditional treatment. Also these providers may have more frequent openings than MDs and PhDs whose practices are full. "
- "A brief explanation of what the mental condition is and an example of a famous person who had the same condition. That would help to normalize mental health. "
- "Treatment success rates for particular categories of services or issues "
- "Positive affirmation throughout the process and crisis line information "
- "A list of mental health conditions from which to select a screening exercise. "
- "Financial assistance providers for services such as Medi-Cal eligibility, low-cost insurance providers, local nonprofits who can provide financial assistance, or other ways to cover the cost for services. "

3. Discussion

The questions, opinions, and suggestions presented by Monterey County community members and professionals throughout this needs assessment process are fundamental contributions towards ensuring that this virtual screening tool is shaped in such a way that best meets the needs of the community. Some of the overarching concerns presented across different topics include the perception that there are not resources available for specific needs or populations, unclear communication and expectations surrounding the help-seeking and referral process, stigma, and the accessibility and safety of a virtual screening tool.

Though this tool is not creating new programs or services, people can be more efficiently linked to local resources tailored to their needs and also be made aware of online self-help tools, therefore expanding their awareness and options for care. Expanding the horizons for support can help historically underserved populations or people with specialized needs get connected to resources they might not otherwise be aware of. It would also help alleviate the burden on MCBH clinicians, particularly when working with beneficiaries who do not meet the eligibility requirements for MCBH programming.

In regards to unclear communication and expectations, we must ensure that, in the development of this tool, people do not receive information or direction that contradicts with or conflicts with any messaging they receive from providers. CredibleMind is making a continued effort to model the virtual referral experience after current MCBH practices and processes. As a tool that may mainly reach people who are not

yet accessing care, there is an opportunity to set a positive and straightforward baseline understanding of the mental health help-seeking process through messaging included on the site. The compilation of information on local resources can also bring providers more direct information around details of services, eligibility requirements, and more areas which are currently difficult to decipher. This tool is theoretically creating another "door" by which people can enter into care—hopefully, it will help minimize the steps between the point of entry and the point of engagement or treatment.

Providing an online mental health resource comes with a mix of unique benefits and concerns. The privacy and anonymity of a screening and referral tool that someone can take using their personal device helps decrease the barrier of stigma around seeking help for mental health. Unfortunately, not all people have access to the internet or an acceptable device to access virtual screening. Additionally, they may lack the digital competence to be able to utilize such a resource. As mentioned previously, there are numerous suggestions around how we can increase accessibility including having schools or libraries include a link to the screening tool on the desktop of their computers, using peer support workers, and establishing kiosks specifically for screening tool administration at ACCESS clinics. This is not a tool that will necessarily be accessible to or preferred by all members of the community, but it certainly has the potential to serve as a welcoming starting point for many people—particularly, younger generations, people reluctant or unable to seek care in person, and people unfamiliar with the mental health system.

In the future, there may be opportunities to expand the reach of this tool by including screening for children younger than 16, adding additional languages, creating a print or phone-based version, and more. Currently, CredibleMind continues to work with Monterey County to develop an initial product that satisfies the most common and most pressing concerns while achieving its principal goals of alleviating the burden on mental health providers and raising awareness of available resources.

4. Limitations

Conducting this needs assessment during the Covid-19 pandemic, which meant having to recruit, promote, and conduct all focus groups and interviews virtually, was a primary barrier. Since we could only conduct focus groups and interviews via Zoom, participants were required to have access to a device that could connect to Zoom as well as data or internet access to participate. In addition, participant recruitment and promotion of focus groups, interviews, and the survey all had to be conducted virtually. Although the statement of work did not state a minimum sample size for the needs assessment, the CredibleMind Research team set target goals of 20-40 participants for focus groups/interviews and 100-200 respondents for the survey. We may have had increased participation and obtained more diverse perspectives if we were able to recruit and conduct research in-person in Monterey County—for example, by tabling in public spaces and asking passersby to complete the survey or going to community agencies and doing outreach for the focus groups and survey.

This limitation also affected our ability to conduct a focus group in Spanish with Spanish language-preferred individuals. To mitigate this limitation, we prioritized recruiting bilingual or multilingual community members and providers who were able to offer us perspectives from within the Spanish-speaking and indigenous Mexican communities in Monterey County.

The needs assessment for this project was also conducted on a timeline that overlapped with MCBH's annual needs assessment. With nearly identical target populations, MCBH staff members and Monterey

County community members were being recruited for multiple surveys, focus groups, and interviews around the same time. The various requests for participation may have felt overwhelming—"survey or respondent fatigue" is a known limitation in needs assessment processes and our efforts coupled with MCBH's efforts likely led to lower survey response and focus group involvement rates.

3.3 Behavioral Health Systems Map

1. Description of Process

From October 2021 to February 2022, the CredibleMind Research team found approximately 200 programs and services in Monterey County related to mental/behavioral health and other related needs using Google, the MCBH website, and MCBH contacts. Resources were initially categorized into a spreadsheet as either mental health resources or "related resources" for services that address other social determinants of mental health.[13] These broad categories were further broken down into various mental health conditions (i.e. trauma, grief/loss, substance use) or other topics (i.e. housing, employment, parenting). In collaboration with MCBH contacts, a form was created that would log more specific information about each resource (i.e. contact information, description, accepted insurance) and populate it into a more comprehensive spreadsheet.[14] Gathering and maintaining the most up-to-date information for these resources will be a continued effort, but the framework has been created so that screening tool results can be populated with this information and MCBH professionals will have additional means for cataloging resources.

Historical data regarding populations served and in need of services for each county, most common mental health conditions, existing services and associated costs for accessing mental health services, and key behavioral health performance measures were gathered from publicly available reports produced by Monterey County.Please see Section 3: Mapping of General Mental Health Landscape for more information.

2. Mapping Counts of Programs and Services

The following outline illustrates the categories of the initial spreadsheet and counts of identified resources. This is by no means an exhaustive list of local programs and resources in Monterey County. As mentioned previously, it serves as a starting point and is likely to grow and expand over time. Please see Appendix J for a copy of the full spreadsheet which includes the name of each resource.

Mental Health Resources (Total count = 107 resources)	**Related Resources (Total count = 99 resources)**
• General Mental/Emotional Health = 29 resources • Substance Use = 33 resources • Youth = 25 resources • Trauma = 16 resources • Birth Support = 3 resources • Grief/Loss = 1 resource	• Physical Health = 14 resources • Housing = 22 resources • Disaster Relief = 1 resources • Internet = 5 resources • Veterans Affairs = 3 resources • Nutrition Services = 11 resources • Employment = 5 resources • Youth Development = 5 resources • Parenting = 16 resources • Immigration = 6 resources • Transportation = 1 resources

[13] See Appendix J: Original systems mapping spreadsheet
[14] See Appendix K: Systems mapping entry form

	• Seniors = 2 resources • Education/Literacy = 2 resources • Caregiving = 3 resources • Deaf/Hard-of-Hearing and Blind = 3 resources

3. Mapping of General Mental Health Landscape

The majority of the information compiled in this section of the report comes from annual data collection compiled by Monterey County government entities. Publicly available documents such as the Monterey County Health Behavioral Health D3 Data Driven Decisions FY 2020/21 report and the most recent years of MCBH and EVALCORP's Mental and Behavioral Health Needs Assessment Summative Report served as the primary sources of information.

Key populations served and in need of services

Fiscal Year 2020-2021 D3 data for Monterey County Behavioral Health System of Care	
13,156	Total Clients Served by Monterey County Behavioral Health System of Care
49%	Male
51%	Female
52%	Latino/a/x/e
48%	Not Latino/a/x/e
17%	Spanish is preferred language
4%	Other language (not English or Spanish) is preferred
411	Age 0-5 clients
3,042	Age 6-15 clients
2,961	Age 16-25 clients
6,094	Age 26-59 clients
1,050	Age 60+ clients
2020 EVALCORP Provider and Community Member survey data ("*The Provider Survey was designed to gather feedback from a broad range of people, agencies, and systems who work directly with persons who are receiving or are in need of mental health services. Respondents invited to take the survey represented multiple service sectors, such as education, law enforcement, hospitals, and other community service agencies and organizations.*")	
79%	Provider respondents who serve persons who are low-income
72%	Provider respondents who serve persons who are trauma-exposed

57%	Provider respondents who serve persons experiencing homelessness

54%	Provider respondents who serve persons experiencing onset of serious psychiatric illness
53%	Provider respondents who serve family members, support persons, or caregivers of individuals with mental health conditions
42%	Provider respondents who serve in the Coastal Region
32%	Provider respondents who serve in North County
75%	Provider respondents who serve in Salinas Valley
36%	Provider respondents who serve in South County
Depression, Substance use, Chronic Stress	Top 3 Community Member respondents' mental and behavioral health issues that were most urgently in need of additional resources
Depression, Substance use, Trauma	Top 3 Provider respondents' mental and behavioral health issues that were most urgently in need of additional resources
Top ten population types that Provider respondents felt had insufficient available services to meet the need or no services available at all. *Percentages represent how many provider respondents selected each population*	
89%	Persons who primarily speak a language other than English or Spanish
87%	Persons experiencing homelessness
86%	Persons with disabilities other than mental/behavioral health conditions (e.g., mobility, hearing, speech, learning, developmental, chronic health conditions like HIV or diabetes, etc.)
86%	Family members, support persons, or caregivers of individuals with mental health conditions
84%	Persons who are low-income
84%	Children/youth at risk of juvenile justice involvement
84%	Children/youth at risk for school failure
83%	Persons who identify as LGBTQ+
83%	Persons who are trauma-exposed

Most common mental health conditions

Fiscal Year 2020-2021 D3 data for Monterey County Behavioral Health System of Care
Top 3 Primary Diagnoses of entire Behavioral Health System of Care clients

28%	Anxiety Disorders
25%	Mood Disorders
13%	Substance Related Addictive D/O
Top 3 Primary Diagnoses of ACCESS to Treatment clients	
32%	Anxiety Disorders
25%	Mood Disorders
5%	Schizophrenia Spectrum
Top 3 Primary Diagnoses of Adult System of Care (ASOC) client	
50%	Schizophrenia Spectrum
30%	Mood Disorders
9%	Substance Related Addictive D/O
Top 3 Primary Diagnoses of Children System of Care (CSOC) clients	
43%	Anxiety Disorders
23%	Mood Disorders
10%	Disruptive Behavior Disorders
Top 3 Primary Diagnoses of Crisis Hospitals and TAR clients	
36%	Mood Disorders
18%	Schizophrenia Spectrum
15%	Anxiety Disorders

Existing services and associated costs for accessing mental health services

Fiscal Year 2020-2021 D3 data for Monterey County Behavioral Health System of Care		
Overall Monterey County Behavioral Health System of Care *Monterey County Behavioral Health System of Care provides services to all age groups. As a safety net provider, Monterey County Behavioral Health strives to align the services we provide with the needs of the general Medi-cal population. We strive to provide community based services that equitably engage our community members.*	13, 156	Number of Clients Served
	$8,525	Avg Service Value per Client
	$112,155,625	Total Service Value
ACCESS to Treatment *Access to Treatment programs are the primary entry point for eligible county residents of Monterey County seeking mental health services. After an initial assessment, treatment services are typically provided in group settings*	6,109	Number of Clients Served
	$2,332	Avg Service Value per

and/or individual counseling sessions that focus on skill-building		

and support.		Client
	$14,250,818	Total Service Value
Adult System of Care (ASOC) *MCBH staff collaborates with local agencies to provide a range of services to adults ages 18 years and older with serious and persistent mental illness.* *The overarching goal is to help consumers establish and/or maintain independence, self-sufficiency and recovery through the provision of integrated healthcare services that includes psychiatric, mental health, physical health and case management services. These services are provided at locations in three (3)regional clinics (Monterey Peninsula, Salinas, and Soledad/King City). The primary goal is to maintain clients in the least restrictive environment to enhance quality of life.*	2,303	Number of Clients Served
	$16,552	Avg Service Value per Client
	$39,792,994	Total Service Value
Children System of Care (CSOC) *County Behavioral Health staff provides services designed to strengthen families with children with serious mental health needs, ranging from assessment, individual, group and family treatment, and psychiatry services. Supportive services are also offered to parents/caregivers of children and youth ages 0 through 25 to better understand their child's mental health condition, which promotes optimal mental health treatment outcomes.*	3,740	Number of Clients Served
	$19,860	Avg Service Value per Client
	$36,879,543	Total Service Value
Crisis Hospital and TAR *Crisis intervention services are provided by a team of County Behavioral Health staff who intervene in situations where an individual's mental or emotional condition results in behavior that may pose an imminent danger to him/herself or to another. Psychiatric inpatient treatment in a hospital setting is provided to individuals who are gravely disabled or likely to do serious harm. Short-term crisis residential services, an alternative to hospitalization, is available for individuals age 18 and above who are experiencing an acute psychiatric episode or crisis, and who do not meet the criteria for acute psychiatric inpatient care. This service is provided by a local agency. State hospitals provide mental health services for individuals on a forensic commitment, as well as for individuals who are under conservatorship and require a secure treatment setting.*	2,215	Number of Clients Served
	$6,034	Avg Service Value per Client
	$13,366,928	Total Service Value
Substance Use Disorders (SUD) *Services consist of intensive structured recovery support for Monterey County residents age 18 years and above with a primary addiction to alcohol/other drugs. Intravenous drug users and HIV+ clients receive priority admission. Narcotic maintenance services are available to Medi-Cal eligible adults with a primary addiction to heroin or other opiates to stabilize and decrease their addiction. These services are provided by local agencies.*	1,519	Number of Clients Served
	$5,177.55	Avg Service Value per Client
	$17,864,697	Total Service Value

Key behavioral health performance measur

The table to the right was provided on page 22 of the 2020-2021 D3 report. It shows the breakdown of service

	Breakdown of Service Type		
	Number of Services	% of Total Service Minutes	% of Clients
Assessment/Evaluation	7,978	26 %	63%
Collateral/Family Therapy	209	0 %	2%
Crisis Intervention	292	0 %	2%
Group Counseling	28	0 %	0%
Linkage/Brokerage	19,066	25 %	72%
Medication Support	3,493	6 %	18%
Mental Health Counseling	4,367	13 %	10%
Non Billable	18,692	14 %	76%

types, number of services per type, % of total service minutes, and % of clients per type for MCBH ACCESS. This chart is also available for the MCBH system as a whole and each of the other four MCBH entities individually. Signs of this project's success should largely be reflected in ACCESS service numbers. As this tool seeks to inform the triage process and also direct

individuals to readily accessible resources, decreases in the "assessment/evaluation" and "linkage/brokerage" metrics would demonstrate positive impact. Through our discussion with MCBH staff, there also seems to be a focus on shifting the percentage of time spent on assessment towards time spent providing treatment.

Additional key performance measures include raising community member and provider awareness of available local resources as well as increased help-seeking behavior due to less stigma. As seen in this table from the 2020 MCBH/EVALCORP Needs Assessment report, over half of providers and community members consider "lack of information about where to get help" a major barrier to accessing care. According to their findings, 44% of community members and 54% of providers consider stigma to be another primary barrier. These sentiments have been confirmed in the needs assessment data collected by CredibleMind as well.

Table 10. Barriers to Accessing Mental and Behavioral Health Services

	Community Member Survey		Provider Survey		Percent change from 2019 to 2020	
Barrier	2019 (n=177)	2020 (n=50)	2019 (n=153)	2020 (n=82)	Community Members	Providers
Lack of information about where to get help	63%	66%	64%	55%	+3%	- 9%
Cost	46%	38%	59%	39%	-6%	-20%
Stigma related to mental illness	46%	44%	58%	54%	-2%	-4%
Service locations are too far away	37%	10%	56%	34%	-27%	-22%
Lack of transportation	35%	16%	69%	44%	-17%	-25%
Lack of health insurance	31%	24%	57%	44%	-7%	-7%

4. Limitations

Though much of the necessary information can be found online, the CredibleMind research team's physical distance from Monterey County presented some barriers in gathering the most comprehensive and rich information for conducting this systems mapping. Because we do not live, work, or receive care in Monterey County, more time had to be spent building some baseline familitary of the current mental health system and how it operates. We were dependent on our MCBH contacts to connect us to the people, organizations, and information sources necessary for this part of the project—our contacts were also very busy conducting their own County needs assessment and performing regular job duties not related to this project. In addition, not being able to visit locations or speak to people in person due to pandemic health precautions likely hampered the scope of the information we were able to collect.

One piece of information that does not currently exist is a comprehensive resource database or directory for mental health and related needs that is updated regularly. It became the work of the CredibleMind Research team to begin compiling this information in order to meet the goals of the systems mapping deliverable. We reviewed and analyzed multiple, less comprehensive lists and put the information together in a spreadsheet as a starting point. Some of the primary available sources include the MCBH ACCESS intake packet, United Way 211, and SAM's Guide, but each was somewhat limited in its scope based on factors such as intended use and target audience.

The overall research phase has also been quite iterative, thus shapeshifting the scope and intention of the systems mapping portion during the course of its timeline. As Monterey County is the pilot county involved in this project, clarity around the intended use, purpose, and goals of this online self-screening and referral tool continue to be a work in progress.

Lastly, goals involving mapping the costs of mental health services similarly lacked clarity, presenting challenges when trying to determine the information that needed to be collected. Cost can involve many facets, and different stakeholders involved in the research process offered varying insights. On the provider side, cost may signify the value of a service, the amount actually paid for a service (not often the same as value), and/or the cost of running a particular program or agency. When mapping a County health system, the focus can be on the costs for County-run programs or instead, consideration of the cost of services amongst all local providers (those affiliated or contracted with the County and those who are not). On the client side, cost may involve out-of-pocket payment for services, insurance deductibles or payments for services, and even expenses for transportation, childcare, or taking time off work. We included cost information related to the current project that was readily available. More data may need to be collected moving forward in order to provide more information on how the screening tool may be impacting mental health system costs.

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Appendix E: Needs Assessment Survey Results

Feedback for New Monterey County Mental Health Self-Screening Tool

CredibleMind Survey Results

Started
93

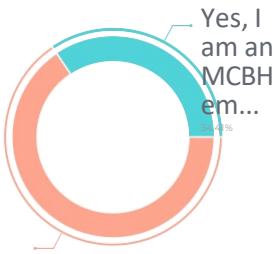
Avg. Time to Complete
6m 35s

Completed
93

QUESTION 01 | MULTIPLE CHOICE

First, we'd like to know if you currently work for Monterey County Behavioral Health (MCBH) as an employee, contractor, or in any other capacity?

Primeramente, nos gustaría saber si ahora mismo, trabaja para la División de Salud Mental



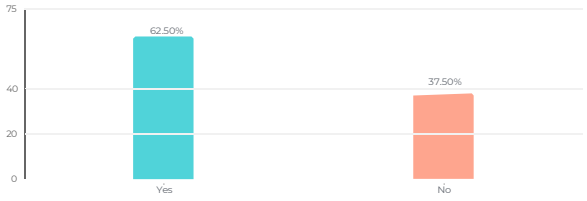
Yes, I am an MCBH employee or wo... No, I am not an MCBH employee no...

ANSWER	RESPONS	RESPONSE PERCENT
Yes, I am an MCBH employee or work for MCBH. // Si, trabajo para o soy un empleado/a de la División de Salud Mental del	32	34.41%
No, I am not an MCBH employee nor do I work for MCBH. // No, no soy un empleado/a ni trabajo para la División de Salud Mental del Condado de	61	65.59

QUESTION 02 | YES OR NO

Do you screen clients for mental health conditions and concerns as part of your job duties?

Screening includes triage and intake



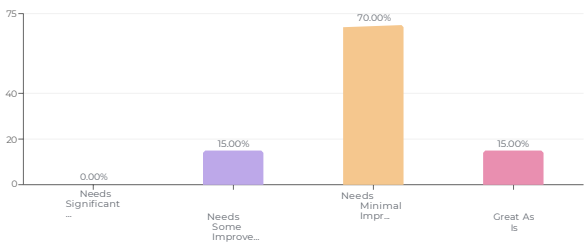
ANSWER CHOICES	RESPONSES	RESPONSE PERCENT AG E
Yes	20	62.50%

FEEDBACK ON 3 Questions

QUESTION 03 | OPINION SCALE

On a scale of 1-4, how would you rate the screening process overall?

Answered: **20**



ANSWER CHOICES	RESPONSES	RESPONSE PERCENT AG E

No	12	37.50%

Needs Significant Improvement	0	0.00%
Needs Some Improvement	3	15.00%
Needs Minimal Improvment	14	70.00%
Great As Is	3	15.00%

FEEDBACK ON SCREENING

QUESTION 04 | MATRIX

Below are some characteristics of screening processes for mental and behavioral health services (screening includes both triage and intake). On a scale of 1-4, how would you rate each

Answered: **20**

	STRONGLY DISAG	DISAG	AG
I am able to accurately identify a client's mental health condition based on MCBH/ACCESS	0	2	13
I spend too much time on	1 (5.00%)	13	4
Clients have appropriate expectations or understanding of the triage and intake process	0	11 (55.00%)	6
Clients feel comfortable being open and honest in	0	5	13
Triage and intake is accessible for non- English	0	2	12
The triage/intake process is able to meet the diverse cultural needs and preferences of the Monterey County	0	6	11 (55.00%)

	STRONGLY DISAGREE	DISAGREE	AGREE
I can easily and reliably share necessary client information with providers outside of my organization or department	4 (20.00%)	9 (45.00%)	7 (35.00%)
Total	**5 (3.57%)**	**48 (34.29%)**	**66**

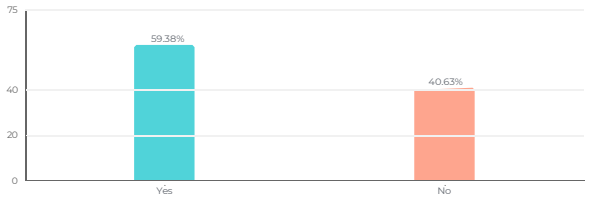
	STRONGLY AG
I am able to accurately identify a client's mental health condition based on MCBH/ACCESS	5
I spend too much time on	2
Clients have appropriate expectations or understanding of the triage and intake process	3 (15.00%)
Clients feel comfortable being open and honest in	2
Triage and intake is accessible for non- English	6
The triage/intake process is able to meet the diverse cultural needs and preferences of the Monterey County	3 (15.00%)
I can easily and reliably share necessary client information with providers outside of my	0

	STRONGLY AG
Total	**21**

QUESTION 06 | YES OR NO

Do you provide clients with referrals as part of your job duties?

Answered: **32** Skipped: **0**



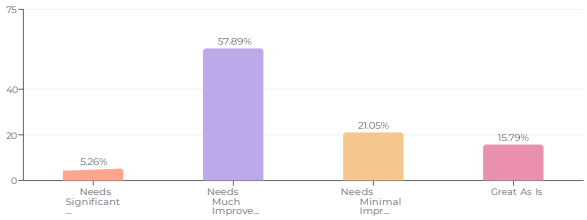
ANSWER CHOICES	RESPONSES	RESPONSE PERCENTAGE
Yes	19	59.38%
No	13	40.63%

FEEDBACK ON 3 Questions

QUESTION 07 | OPINION SCALE

On a scale of 1-4, how would you rate referral procedures overall?

Answered: **19**



ANSWER	RESPONS	RESPONSE PERCENT
Needs Significant	1	5.26%
Needs Much	11	57.89
Needs Minimal Improvement	4	21.05%
Great As Is	3	15.79%

FEEDBACK ON REFERRALS

QUESTION 08 | MATRIX

Below are some characteristics of referral procedures for mental and behavioral health services. On a scale of 1-4, how would you generally

Answered: **19**

	NEEDS SIGNIFICANT	NEEDS SOME	NEEDS MINIMAL
Your familiarity with available resources or ability to access a	2 (10.53%)	7	9
Community resource information is up-to- date (contact information, services	4 (21.05%)	11 (57.89%)	3 (15.79%)
Ability of clients to get in contact and register with the referred services	5	9	4 (21.05%)
Availability of culturally aligned and language accessible resources	2 (10.53%)	8 (42.11%)	6 (31.58%)
Ease of ensuring that clients are eligible for the services referred to	3 (15.79%)	8 (42.11%)	6 (31.58%)
Availability of resources for most needs	8 (42.11%)	7 (36.84%)	3 (15.79%)

	NEEDS SIG NIFICANT	NEEDS SOME	NEEDS MINIMAL
Ease of sharing information between your agency or department and a referral agency (i.e. the client experiences a more seamless transition because the referral	4 (21.05%)	8 (42.11%)	6 (31.58%)
Total	**28**	**58**	**37**

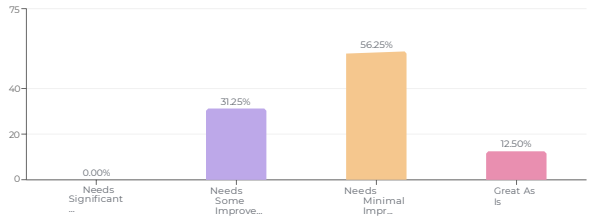
	GREAT AS
Your familiarity with available resources or ability to access a	1 (5.26%)
Community resource information is up-to- date (contact information, services	1 (5.26%)
Ability of clients to get in contact and register with the referred services	1 (5.26%)
Availability of culturally aligned and language	3 (15.79%)
Ease of ensuring that clients are eligible for the services referred	2 (10.53%)
Availability of resources for most needs	1 (5.26%)

	GREAT AS
Ease of sharing information between your agency or department and a referral agency (i.e. the client experiences a more seamless transition because the referral	1 (5.26%)
Total	**10**

QUESTION 10 | OPINION SCALE

On a scale of 1-4, how would you rate Monterey County's current offering of mental health and behavioral health services?

Answered: **32** Skipped: **0**

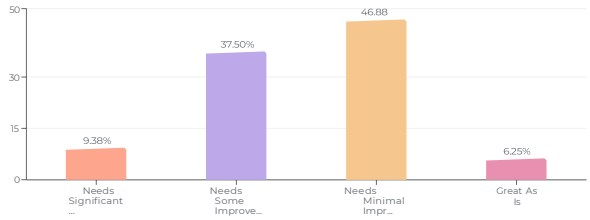


ANSWER CHOICES	RESPONSES	RESPONSE PERCENTAGE
Needs Significant Improvement	0	0.00%
Needs Some Improvement	10	31.25%
Needs Minimal Improvement	18	56.25%
Great As Is	4	12.50%

QUESTION 11 | OPINION SCALE

On a scale of 1-4, how would you rate Monterey County's offering of services and programs' current ability to meet the needs of the community in Monterey County?

Answered: **32** Skipped: **0**

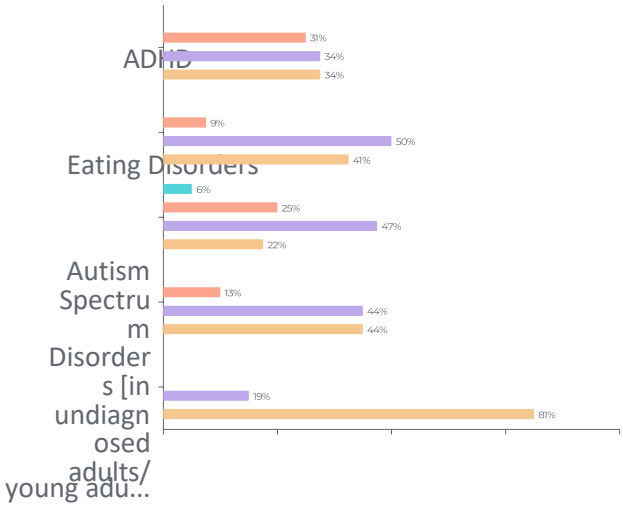


ANSWER CHOICES	RESPONSES	RESPONSE PERCENTAGE
Needs Significant Improvement	3	9.38%
Needs Some Improvement	12	37.50%
Needs Minimal Improvement	15	46.88%
Great As Is	2	6.25%

QUESTION 13 | MATRIX

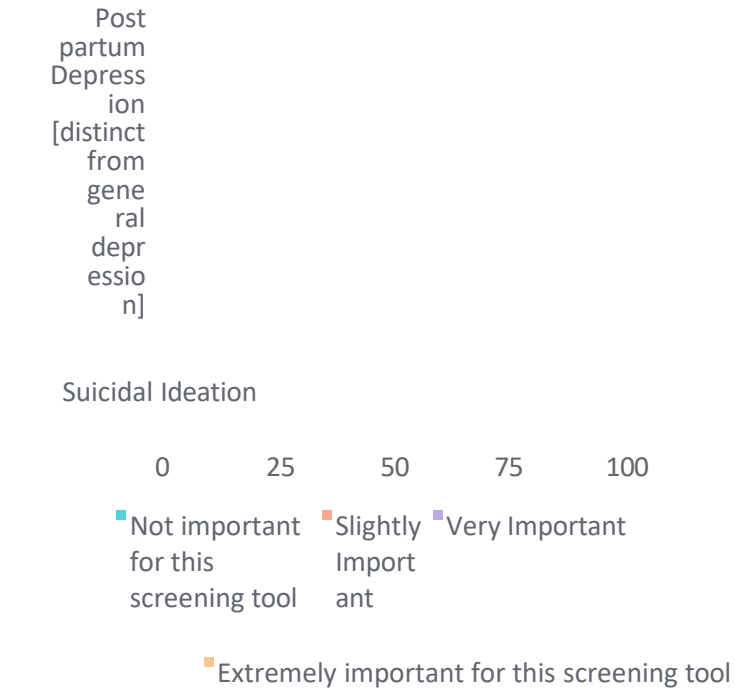
The screening tool we are creating will screen people age 16 and older for the following conditions: Anxiety, Depression, Bipolar Disorders, Post Traumatic Stress Disorder (PTSD), Psychosis/Schizophrenia, and Substance Use Disorders. Below is a list of other mental health conditions we are also considering screening for.

Answered: **32**



	NOT IMPORTANT FOR THIS SCREENING TOOL	SLIGHTLY IMPORTANT	VERY IMPORTANT
ADHD	0 (0.00%)	10 (31.25%)	11 (34.38%)
Eating Disorders	0 (0.00%)	3 (9.38%)	16 (50.00%)
Autism Spectrum Disorders [in undiagnosed adults/ young adults]	2 (6.25%)	8 (25.00%)	15 (46.88%)
Postpartum Depression [distinct from general depression]	0 (0.00%)	4 (12.50%)	14 (43.75%)
Suicidal Ideation	0 (0.00%)	0 (0.00%)	6 (18.75%)
Total	**2 (1.25%)**	**25 (15.63%)**	**62 (38.75%)**

	EXTREMELY IMPORTANT FOR THIS SCREENING TOOL
ADHD	11 (34.38%)
Eating	13
Autism Spectrum Disorders [in undiagnosed adults/ young	7 (21.88%)
Postpartum Depression [distinct from	14
Suicidal	26 (81.25%)
Total	**71**


Post partum Depression [distinct from general depression]
Suicidal Ideation
0
25
50
75
100
Not important for this screening tool
Slightly Important
Very Important
Extremely important for this screening tool

FEEDBACK ON THE SCREENING TOOL DESIGN

QUESTION 15 | MULTIPLE CHOICE

Below is a list of factors that impact behavioral health which we are also considering including in the screening tool. Please select any factors you believe are important to include in this screening tool as it relates to addressing a client's mental health needs.

You may select "Other" and type in any additional factors not already listed.

Answered: **32** Skipped: **0**

ANSWER	RESPONS	RESPONSE PERCENT
Physical Health Status (i.e. chronic pain or other medical	27	10.71%
Housing	26	10.32%
Access to	18	7.14%
History of	32	12.70%
Insurance/Medi-Cal	23	9.13%
Food	27	10.71%
Employment	17	6.75%
Extent of Social	23	9.13%
Sleep	25	9.92
Immigration	13	5.16%
History of	18	7.14%
Othe	3	1.19%

FEEDBACK ON THE SCREENING TOOL DESIGN

QUESTION 16 | RANK ORDER

We are considering different ways you could share this online screening tool with beneficiaries who may benefit from it.
Please rank the following options from 1-5 with 1 = The option you would use the most and 5 = The

Answered: **32**

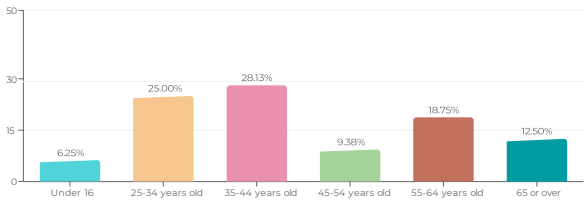
ANSWER	AVERAG	RESPONSE PERCENT
Send client a text from your work phone 21.60 or computer with the link to the screening tool		22.50
Have client text SCREENING to a number, 19.00 and client receives a text with a link to		19.79%
Send or display a QR code for client to scan	16.0	16.67%
Use email or other online messaging service to share access to the screening tool	20.8	21.67%
Hand out or display physical flyer, brochure or other	18.60	19.38%

DEMOGRAPHIC QUEST 5 Questions

QUESTION 17 | MULTIPLE CHOICE

What is your age

Answered: **32**



ANSWER CHOICES	RESPONSES	RESPONSE PERCENTAGE
Under 16	2	6.25%
25-34 years old	8	25.00%
35-44 years old	9	28.13%
45-54 years old	3	9.38%
55-64 years old	6	18.75%
65 or over	4	12.50%

DEMOGRAPHIC QUESTIONS

QUESTION 18 | MULTIPLE CHOICE

What is your

Answered: **32**

ANSWER CHOICES	RESPONSES	RESPONSE PERCENTAGE
Woman	24	75.00%
Man	8	25.00%
Non-binary	0	0.00%
Other	0	0.00%

DEMOG RAPHIC QUEST IONS

QUEST ION 21 | MULTIPLE CHO ICE

What is your job

Answered: **32**

ANSWER	RESPONS	RESPONSE PERCENT
Individual contributor, Administrative, Entry-level	12	37.50
Team lead, Manager,	12	37.50
Senior-level	8	25.00

QUEST ION 22 | CO NSENT/AGREEMENT

You said that you do NOT work for Monterey County, so you will have a chance to win one of fifteen $50 Mastercard gift cards at the end of this survey. Please remember to tell the truth. Your answers are anonymous and your name or contact information will NOT be shared with Monterey County or any other government agency.

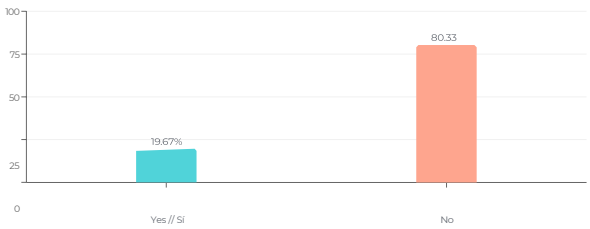
Dijo que no trabaja para el Condado de Monterey

ANSWER	RESPONS	RESPONSE PERCENT
Agre	61	100.00

QUEST ION 23 | YES O R NO

Have you (or an adult that you are responsible for) ever talked to a Monterey County Behavioral Health (MCBH) or ACCESS representative to request services?

¿Alguna vez usted (o un adulto/a del cual usted es responsable) ha hablado con un

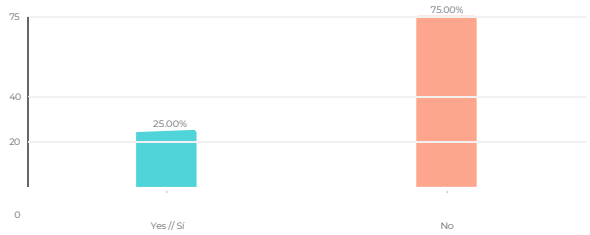


ANSWER	RESPONS	RESPONSE PERCENT
Yes // Sí	12	19.67%
N	49	80.33

QUEST ION 24 | YES O R NO

Do you (or an adult that you are responsible for) currently have a Monterey County Behavioral Health case manager?

¿Tiene usted (o un adulto/a del cual usted es responsable) un administrador de caso de la



ANSWER	RESPONS	RESPONSE PERCENT
Yes // Sí	3	25.00
N	9	75.00

QUESTION 25 | MULTIPLE CHOICE

What was your first step to seeking MCBH services? (Select all that apply)

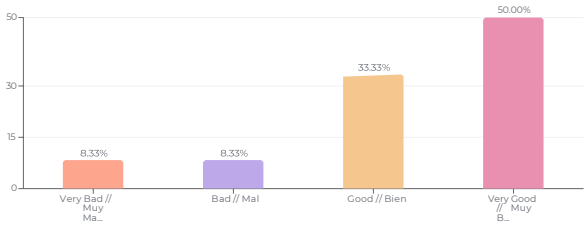
¿Cuál fue su primer paso para pedir servicios con la División de Salud Mental del Condado de

ANSWER	RESPONS	RESPONSE PERCENT
I called an ACCESS location or the toll- 4 free line. // Llamé una ubicación de		26.67
I visited an ACCESS location in person. // 1 Visité una ubicación de ACCESO en		6.67
I was referred to MCBH services by a 7 social worker, therapist, medical staff, school staff, or other professional. // Una trabajadora social, terapeuta, personal médico, personal de la escuela, u otro profesional me refirió a		46.67
I was referred to MCBH services by al friend or family member. // Un amigo, miembro de la familia, u otro ser querido me refirió a servicios de la División de Salud		6.67
Other // Algo	2	13.33%

QUESTION 26 | OPINION SCALE

How would you rate your experience with Monterey County Behavioral Health screening? (Screening involves the first 1-3 conversations you ever had with ACCESS or MCBH staff where you asked for help and talked about what supports you may need and qualify for)

¿Cómo calificaría su experiencia con el proceso



ANSWER	RESPONS	RESPONSE PERCENT
Very Bad // Muy	1	8.33%
Bad //	1	8.33%
Good //	4	33.33%
Very Good // Muy	6	50.00

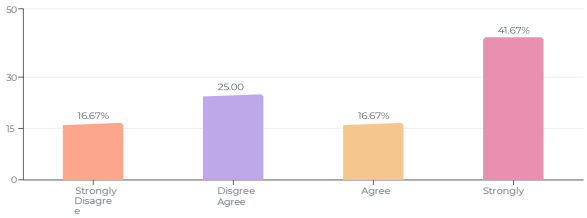
SCREENING // 6 Questions

QUESTION 27 | OPINION SCALE

It was easy to get in contact with ACCESS/MCBH staff the first time I requested services.

Fue fácil ponerse en contacto con el personal de ACCESO/la División de Salud Mental la primera vez que solicité servicios.

Answered: **12** Skipped: **0**



ANSWER CHOICES	RESPONSES	RESPONSE PERCENT AGE
Strongly Disagree	2	16.67%
Disgree	3	25.00%
Agree	2	16.67%
Strongly Agree	5	41.67%

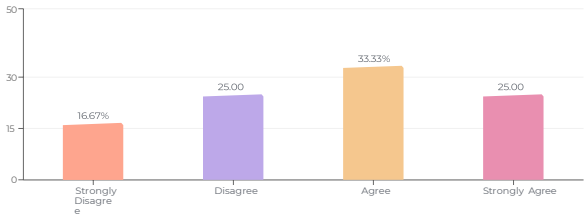
SCREENING // EVALUACIÓN

QUESTION 28 | OPINION SCALE

The amount of time it took to complete my screening or intake was reasonable.

El tiempo que tomó completar mi evaluación o admisión fue razonable.

Answered: **12** Skipped: **0**



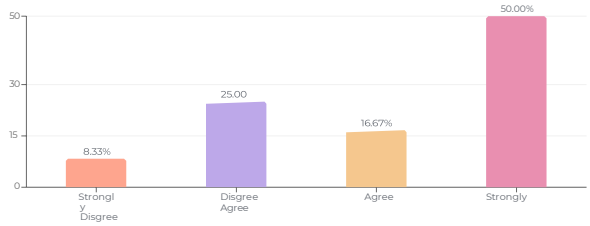
ANSWER CHOICES	RESPONSES	RESPONSE PERCENT AGE
Strongly Disagree	2	16.67%
Disagree	3	25.00%
Agree	4	33.33%
Strongly Agree	3	25.00%

QUESTION 29 | OPINION SCALE

I clearly understood the screening process and the questions asked of me.

Entendí claramente el proceso de evaluación y las preguntas que me hicieron.

Answered: **12** Skipped: **0**



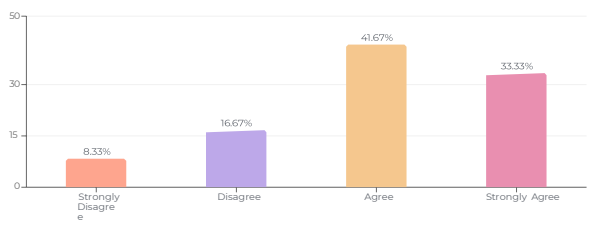
ANSWER CHOICES	RESPONSES	RESPONSE PERCENTAGE
Strongly Disgree	1	8.33%
Disgree	3	25.00%
Agree	2	16.67%
Strongly Agree	6	50.00%

QUESTION 30 | OPINION SCALE

I felt comfortable sharing personal information with the person screening me.

Me sentí cómodo compartiendo información personal con la persona que me evaluó.

Answered: **12** Skipped: **0**



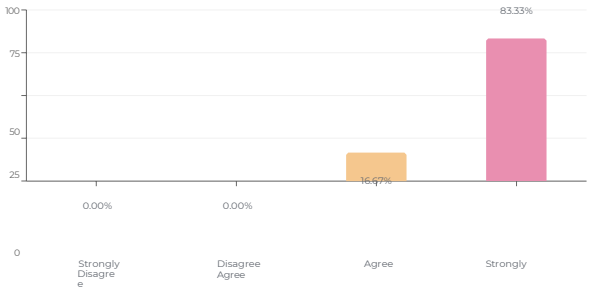
ANSWER CHOICES	RESPONSES	RESPONSE PERCENTAGE
Strongly Disagree	1	8.33%
Disagree	2	16.67%
Agree	5	41.67%
Strongly Agree	4	33.33%

QUESTION 31 | OPINION SCALE

I could talk to MCBH or ACCESS staff in my preferred language.

Podría hablar con el personal de ACCESO o la División de Salud Mental en mi idioma preferido.

Answered: **12** Skipped: **0**



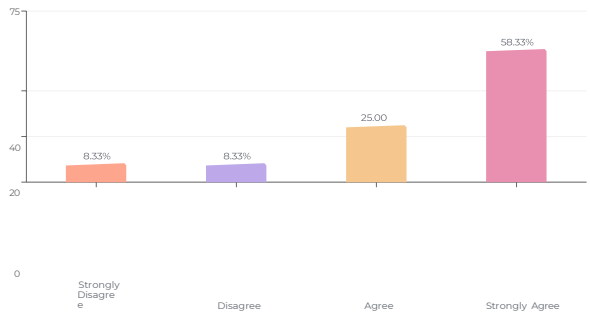
ANSWER CHOICES	RESPONSES	RESPONSE PERCENTAGE
Strongly Disagree	0	0.00%
Disagree	0	0.00%
Agree	2	16.67%
Strongly Agree	10	83.33%

QUESTION 32 | OPINION SCALE

I agreed with the results and suggestions provided to me at the end of my screening.

Estuve de acuerdo con los resultados y las sugerencias que se me proporcionaron al final de mi evaluación.

Answered: **12** Skipped: **0**



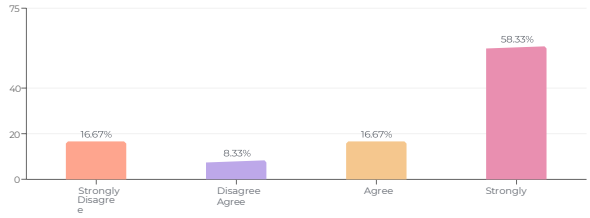
ANSWER CHOICES	RESPONSES	RESPONSE PERCENTAGE
Strongly Disagree	1	8.33%
Disagree	1	8.33%
Agree	3	25.00%
Strongly Agree	7	58.33%

QUESTION 33 | OPINION SCALE

I was connected to the type of services I was hoping for.

Yo estaba conectado al tipo de servicios que esperaba.

Answered: **12** Skipped: **0**



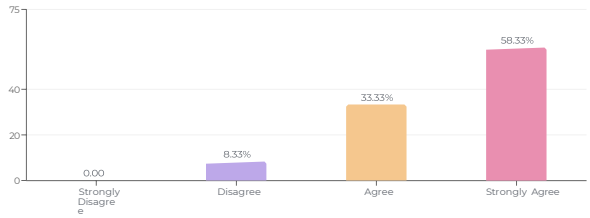
ANSWER CHOICES	RESPONSES	RESPONSE PERCENTAGE
Strongly Disagree	2	16.67%
Disagree	1	8.33%
Agree	2	16.67%
Strongly Agree	7	58.33%

QUESTION 34 | OPINION SCALE

The address, contact information, and/or hours of service were correct for the referral I received.

La dirección, la información de contacto y/o las horas de servicio eran correctas para la referencia que recibí.

Answered: **12** Skipped: **0**



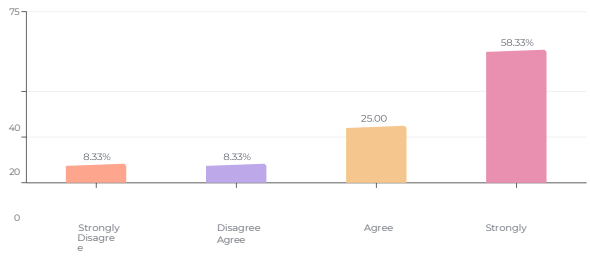
ANSWER CHOICES	RESPONSES	RESPONSE PERCENTAGE
Strongly Disagree	0	0.00%
Disagree	1	8.33%
Agree	4	33.33%
Strongly Agree	7	58.33%

QUESTION 35 | OPINION SCALE

I could easily get in contact with the organization I was referred to.

Fácilmente podría ponerme en contacto con la organización a la que me recomendaron.

Answered: **12** Skipped: **0**



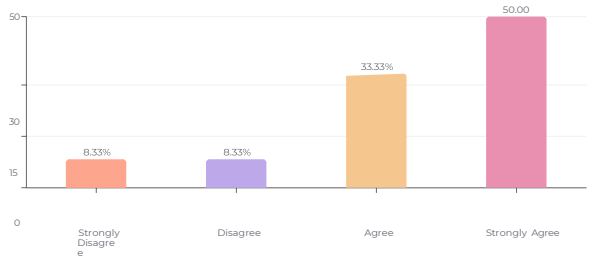
ANSWER CHOICES	RESPONSES	RESPONSE PERCENTAGE
Strongly Disagree	1	8.33%
Disagree	1	8.33%
Agree	3	25.00%
Strongly Agree	7	58.33%

QUESTION 36 | OPINION SCALE

The services I was referred to matched my cultural preferences or reflected my identity.

Los servicios a los que me refieron coinciden con mis preferencias culturales o reflejan mi identidad.

Answered: **12** Skipped: **0**



ANSWER CHOICES	RESPONSES	RESPONSE PERCENTAGE
Strongly Disagree	1	8.33%
Disagree	1	8.33%
Agree	4	33.33%
Strongly Agree	6	50.00%

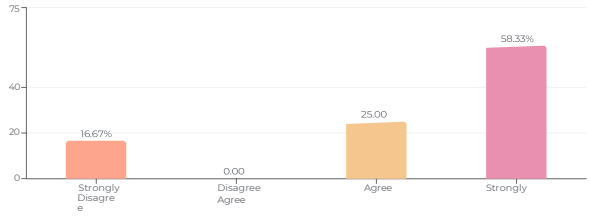
REFERRALS // REFERENCIAS

QUESTION 37 | OPINION SCALE

I was eligible for the services that I was referred to.

Yo era elegible para los servicios a los que me remitieron.

Answered: **12** Skipped: **0**



ANSWER CHOICES	RESPONSES	RESPONSE PERCENTAGE
Strongly Disagree	2	16.67%
Disagree	0	0.00%
Agree	3	25.00%
Strongly Agree	7	58.33%

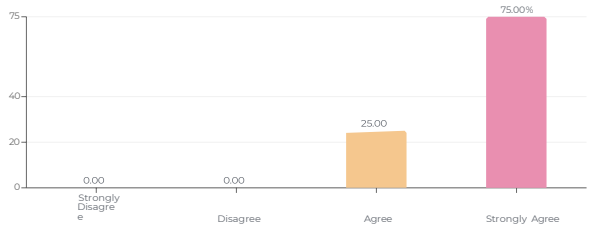
REFERRALS // REFERENCIAS

QUESTION 38 | OPINION SCALE

The services I was referred to were available in my preferred language.

Los servicios a los que me refirieron estaban disponibles en mi idioma preferido.

Answered: **12** Skipped: **0**



ANSWER CHOICES	RESPONSES	RESPONSE PERCENTAGE
Strongly Disagree	0	0.00%
Disagree	0	0.00%
Agree	3	25.00%
Strongly Agree	9	75.00%

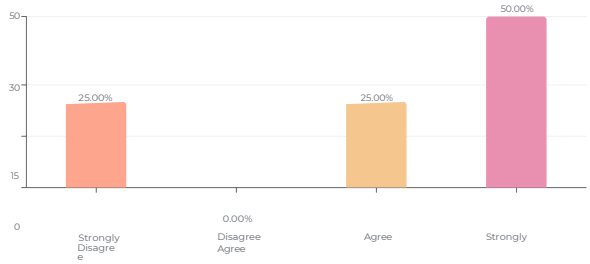
REFERRALS // REFERENCIAS

QUESTION 39 | OPINION SCALE

I could easily access the services I was referred to (for example, you could find transportation to get there, you did not have to drive too far, or there were online options, etc.)

Podía acceder fácilmente a los servicios a los que me referían (por ejemplo, podía encontrar transporte para llegar allí, no tenía que conducir demasiado, o había opciones en línea, etc.)

Answered: **12** Skipped: **0**



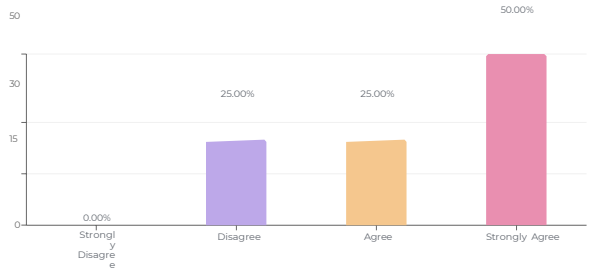
ANSWER CHOICES	RESPONSES	RESPONSE PERCENTAGE
Strongly Disagree	3	25.00%
Disagree	0	0.00%
Agree	3	25.00%
Strongly Agree	6	50.00%

REFERRALS // REFERENCIAS

QUESTION 40 | OPINION SCALE

Any questions or concerns I had with the referral process were answered in a reasonable amount of time.

Cualquier pregunta o inquietud que tuve con el proceso de referencia fue respondida en un período de tiempo razonable.

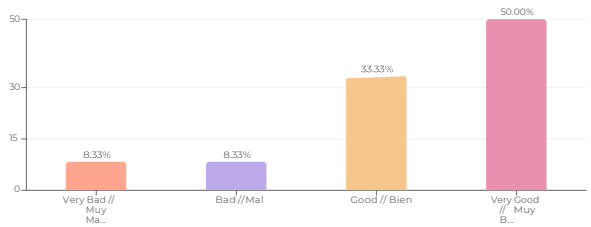


ANSWER CHOICES	RESPONSES	RESPONSE PERCENTAGE
Strongly Disagree	0	0.00%
Disagree	3	25.00%
Agree	3	25.00%
Strongly Agree	6	50.00%

QUESTION 41 | RATING

On a scale of 1-4, how would you rate MCBH overall?

En una escala del 1 al 4, ¿cómo calificaría a la División de Salud Mental del Condado de Monterey en

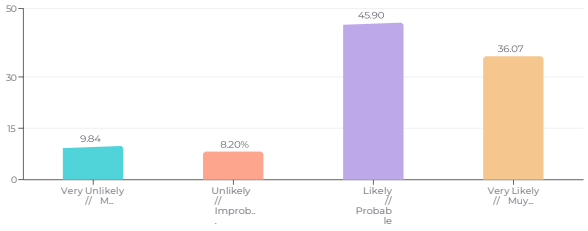


ANSWER	RESPONS	RESPONSE PERCENT
Very Bad // Muy	1	8.33%
Bad	1	8.33%
Good //	4	33.33%
Very Good // Muy	6	50.00

QUESTION 43 | MULTIPLE CHOICE

We are creating a mental health quiz that you can take on your phone, computer, or other mobile device. It will let you know what mental health challenges you may have and let you know about online and local resources based on your results. It would take less than 15 minutes to complete and you would have the choice to send your results to Monterey County Behavioral Health, a different provider, or keep your results private. Please rate how likely you are to take this quiz.

Estamos creando un cuestionario para salud mental que puede completar en su celular

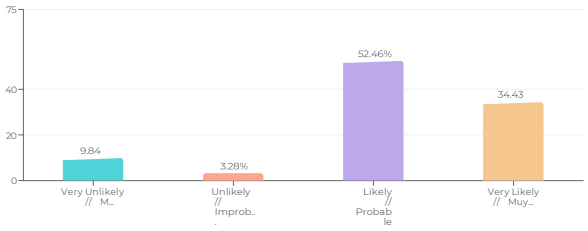


ANSWER CHOICES	RESPONSES	RESPONSE PERCENT AGE
Very Unlikely // Muy improbable	6	9.84%
Unlikely // Improbable	5	8.20%
Likely // Probable	28	45.90%
Very Likely // Muy probable	22	36.07%

QUESTION 44 | MULTIPLE CHOICE

How likely are you to recommend this quiz to a friend, family member, or other loved one?

¿Qué probabilidad hay de que recomiende esta cuestonario a un amigo, familiar u otro ser querido?

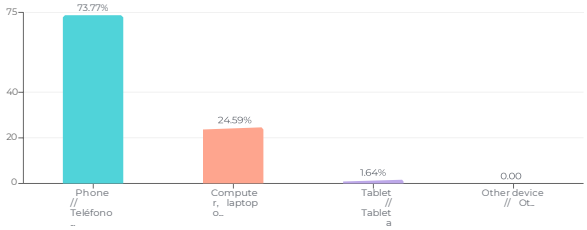


ANSWER CHOICES	RESPONSES	RESPONSE PERCENT AGE
Very Unlikely // Muy improbable	6	9.84%
Unlikely // Improbable	2	3.28%
Likely // Probable	32	52.46%
Very Likely // Muy probable	21	34.43%

QUESTION 45 | MULTIPLE CHOICE

What type of device do you use the most for your online activities?

¿Qué tipo de aparato utiliza más para sus actividades en línea?

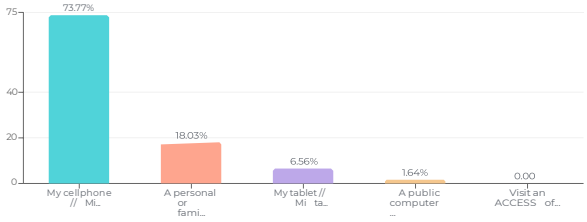


ANSWER CHOICES	RESPONSES	RESPONSE PERCENTAGE
Phone // Teléfono móvil	45	73.77%
Computer, laptop or desktop // Computadora, portátil o sobremesa	15	24.59%
Tablet // Tableta	1	1.64%
Other device // Otro aparato de tecnología	0	0.00%

QUESTION 46 | MULTIPLE CHOICE

If this quiz became available tomorrow, what device would you most likely use to take it?

Si este cuestionario estuviera disponible mañana, ¿qué aparato probablemente usaría para



ANSWER CHOICES	RESPONSES	RESPONSE PERCENTAGE
My cellphone // Mi teléfono móvil	45	73.77%
A personal or family computer, laptop or desktop // Una computadora, portátil o sobremesa personal o familiar	11	18.03%
My tablet // Mi tableta	4	6.56%
A public computer such as at the library or school // Una computadora pública como en la biblioteca o la escuela	1	1.64%
Visit an ACCESS office and take it on a private computer in their lobby (Visitaría una oficina de ACCESO y lo tomaría en una computadora privada en su vestíbulo)	0	0.00%

QUESTION 47 | RANK ORDER

We are thinking about different ways someone in the community can find out about the quiz. Please rank these options with 1 = The option you would use the most and 5 = The option you would use the least.

Estamos pensando en diferentes formas en que

ANSWER	AVERAGE	RESPONSE PERCENT
An MCBH staff member texts you with a link to the quiz. // Un miembro del equipo de la División de Salud Mental le envía un mensaje de	40.20	21.97%
You text SCREENING to a specific phone number and you receive a text with a link to the quiz. // Ud. envía un texto con el mensage SCREENING a un número y recibe un mensaje	43.20	23.61%
You scan a QR code using your phone or other device. // Ud. escanea un código	35.40	19.34%
You receive an email with a link to the quiz. // Recibe un correo	36.00	19.67%
You see or receive a physical flyer, brochure or other marketing material about the quiz. // Vee o recibe un folleto u otro material	28.20	15.41%

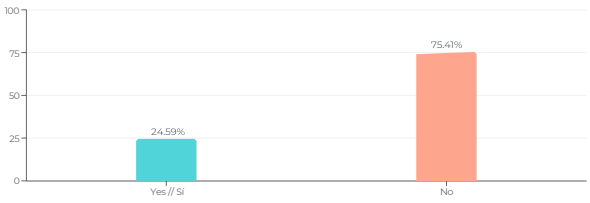
PLEASE SELECT IF YOU WOULD USE THESE OPTIONAL 7 Questions

QUESTION 48 | YES OR NO

Share my quiz results with family and friends.

Comparte mis resultados de este cuestionario con mis familiares o amigos.

Answered: **61** Skipped: **0**



ANSWER	RESPONSES	RESPONSE PERCENT
Yes // Sí	15	24.59
N	46	75.41%

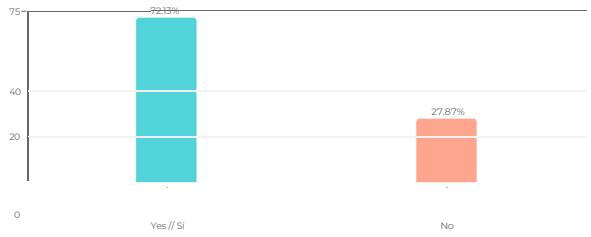
PLEASE SELECT IF YOU WOULD USE THESE OPTIONAL FEATURES OR N...

QUESTION 49 | YES OR NO

Forward quiz results to a mental health provider.

Comparte resultados de este cuestionario a un doctor o otra profesional de salud mental.

Answered: **61** Skipped: **0**



ANSWER	RESPONS	RESPONSE PERCENT
Yes // Sí	4	72.13%
N	17	27.87

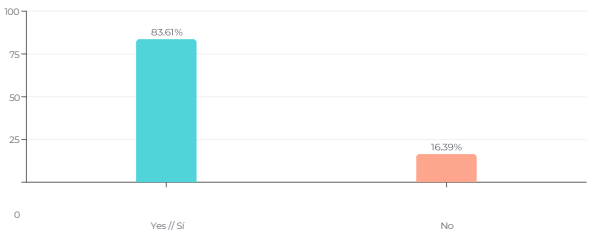
PLEASE SELECT IF YOU WOULD USE THESE OPTIONAL FEATURES OR N...

QUESTION 50 | YES OR NO

Look at my past quiz results.

Ver a mis resultados pasados.

Answered: **61** Skipped: **0**



ANSWER	RESPONS	RESPONSE PERCENT
Yes // Sí	51	83.61%
N	10	16.39%

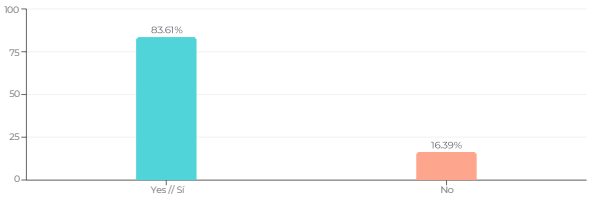
PLEASE SELECT IF YOU WOULD USE THESE OPTIONAL FEATURES OR N...

QUESTION 51 | YES OR NO

Receive referrals to online self-help resources in addition to local in-person resources.

Recibe recomendaciones a recursos de esfuerzo personal en línea además de recursos locales en persona.

Answered: **61** Skipped: **0**



ANSWER	RESPONS	RESPONSE PERCENT
Yes // Sí	51	83.61%
N	10	16.39%

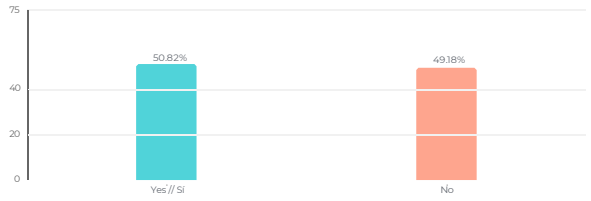
PLEASE SELECT IF YOU WOULD USE THESE OPTIONAL FEATURES OR N...

QUESTION 52 | YES OR NO

Print my quiz results.

Imprime mis resultados del cuestionario.

Answered: **61** Skipped: **0**



ANSWER	RESPONS	RESPONSE PERCENT
Yes // Sí	31	50.82
N	30	49.18%

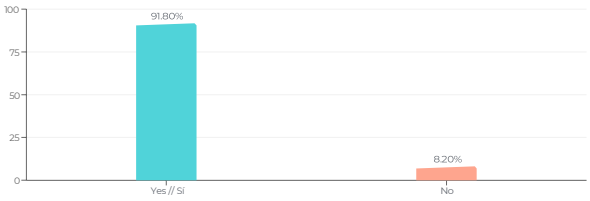
PLEASE SELECT IF YOU WOULD USE THESE OPTIONAL FEATURES OR N...

QUESTION 53 | YES OR NO

View County resources and services that accept my insurance.

Ver recursos y servicios en el Condado de Monterey que aceptan mi seguro médico.

Answered: **61** Skipped: **0**



ANSWER	RESPONS	RESPONSE PERCENT
Yes // Sí	56	91.80%
N	5	8.20

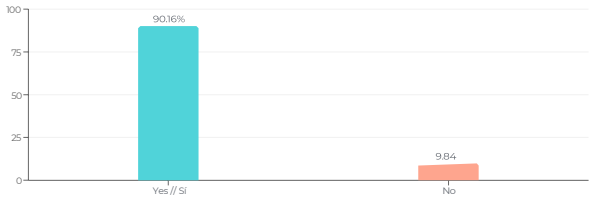
PLEASE SELECT IF YOU WOULD USE THESE OPTIONAL FEATURES OR N...

QUESTION 54 | YES OR NO

View County resources and services based on my location.

Ver recursos y servicios en el Condado de Monterey según de mi locación.

Answered: **61** Skipped: **0**



ANSWER	RESPONS	RESPONSE PERCENT
Yes // Sí	55	90.16%
N	6	9.84

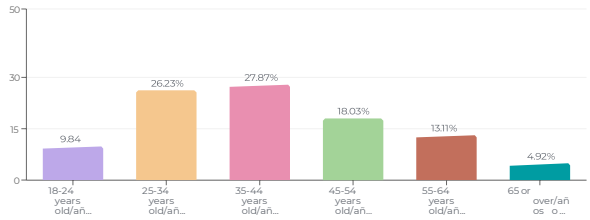
DEMOGRAPHICS // DATOS DEMOG 7 Questions

QUESTION 56 | MULTIPLE CHOICE

What is your age range?

¿Cuál es su rango de edad?

Answered: **61** Skipped: **0**



ANSWER CHOICES	RESPONSES	RESPONSE PERCENT AGE
18-24 years old/años	6	9.84%
25-34 years old/años	16	26.23%
35-44 years old/años	17	27.87%
45-54 years old/años	11	18.03%
55-64 years old/años	8	13.11%
65 or over/años o más	3	4.92%

DEMOGRAPHICS // DATOS DEMOGRÁFICOS

QUESTION 57 | MULTIPLE CHOICE

What is your gender?

¿Cuál es su género?

Answered: **61** Skipped: **0**

ANSWER	RESPONS	RESPONSE PERCENT
Woman //	54	88.52
Man //	6	9.84
Non-Binary // No	1	1.64%
Other // Otro	0	0.00

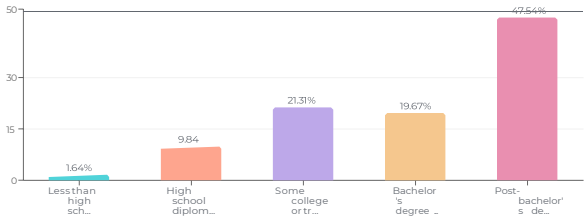
DEMOG RAPHICS // DAT OS DEMOG RÁFICOS&#65533;

QUEST ION 59 | MULTIPLE CHO ICE

What is your highest level of education?

¿Cual es su nivel más alto de educación?

Answered: **61** Skipped: **0**



ANSWER CHOICES	RESPONSES	RESPONSE PERCENT AG E
Less than high school // Menos de secundaria	1	1.64%
High school diploma or GED // Secundaria	6	9.84%
Some college or trade school // Escuela de oficio o universitaria pero incompleta	13	21.31%
Bachelor's degree // Licenciatura universitaria	12	19.67%
Post-bachelor's degree i.e. master's, doctorate // Maestria o doctorado	29	47.54%

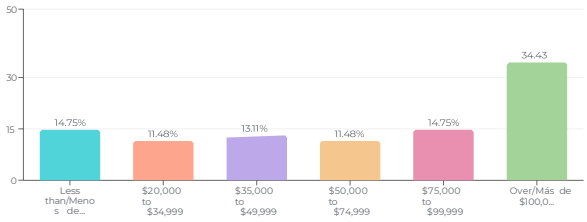
DEMOG RAPHICS // DAT OS DEMOG RÁFICOS&#65533;

QUEST ION 60 | MULTIPLE CHO ICE

What is your household income level?

¿Cuál es el nivel de ingresos de su hogar?

Answered: **61** Skipped: **0**



ANSWER CHOICES	RESPONSES	RESPONSE PERCENT AG E
Less than/Menos de $20,000	9	14.75%
$20,000 to $34,999	7	11.48%
$35,000 to $49,999	8	13.11%
$50,000 to $74,999	7	11.48%
$75,000 to $99,999	9	14.75%
Over/Más de $100,000	21	34.43%

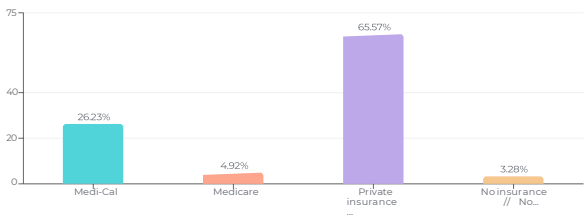
DEMOG RAPHICS // DAT OS DEMOG RÁFICOS&#65533;

QUEST ION 61 | MULTIPLE CHO ICE

Do you have health insurance? (Check all that apply)

¿Tienes seguro médico? (Marque todo lo que corresponda)

Answered: **61** Skipped: **0**



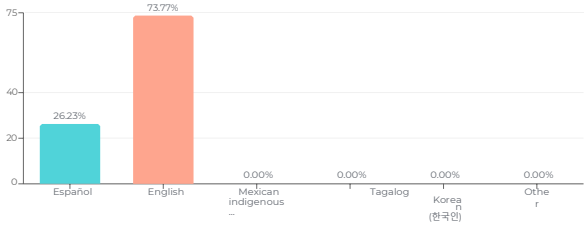
DEMOG RAPHICS // DAT OS DEMOG RÁFICOS&#65533;

QUEST ION 62 | MULTIPLE CHO ICE

What language do you speak most at home?

¿Qué idioma hablas más en casa?

Answered: **61** Skipped: **0**



ANSWER CHOICES	RESPONSES	RESPONSE PERCENT AG E
Medi-Cal	16	26.23%
Medicare	3	4.92%
Private insurance // Seguro médico privada	40	65.57%
No insurance // No seguro médico	2	3.28%

ANSWER CHOICES	RESPONSES	RESPONSE PERCENT AG E
Español	16	26.23%
English	45	73.77%
Mexican indigenous language or dialect // Lengua o dialecto indígena mexicano como Mixteco, Triqui, o Chatino	0	0.00%
Tagalog	0	0.00%
Korean (한국인)	0	0.00%
Other	0	0.00%

Appendix F: Functional Design Document

CredibleMind

4.0 Functional Design Document

Introduction

MAY 11, 2022

The following pages include summaries and required deliverables for 4.0-4.4 Functional Design Document for the Help@Hand screening application project. All parts are listed in the Table of Contents below.

Table of Contents

Additional Appendices (Not attached to this document)

C. Draft of screening questions in English and Spanish.pdf
D. Screener components.xlsx
E. Help at Hand Screening May User Test Mock Ups.pdf

CredibleMind

Design Document

Introduction to Design Processes

After the completion of the Research phase, the CredibleMind Technology team initiated the Design phase by developing user personas (pages 6-7) and user journeys (Appendix A in this document) for the screening application. These elements reflected the need for a responsive design that adapts easily for anonymous users so that the application can be used by infrequent users without training. The screening answers and results cannot be associated through personally identifiable information (PII). The contract calls for the experience to be offered in English and Spanish. The business logic and content maintenance over time needs to be highly configurable for each county.

The following user experiences will be achieved through an anonymous community user profile design, a signed-in community user profile design, an anonymous clinical user design, and an "At the Clinic Mode". The information architecture will be managed through a content management system design for counties, screening tools, referral information, and local resources. The content management system design includes localization for the display of English and Spanish languages.

Community Users

First, user profile designs for people taking the screener will be designed for both anonymous and signed-in users. A user may take the screener as many times as they like and will be issued an anonymous *Access Code*[1] for each result. The user will have the option to share the *Access Code* with a provider or other professional. The shared *Access Code* will need to be provided along with the county's URL and the person's identifiable information via a secure method such as calling the clinic or using a patient portal. The *Access Code* alone will lead to completely anonymous results. Alternatively, the signed-in user will be able to view prior screener results in their user profile history and receive results to the email address associated with their user account. If a signed-in user chooses to share their results via an *Access Code*, the results will also be anonymous to protect privacy and confidentiality. Results will emphasize a referral opportunity if the site is not set to At the Clinic Mode.

Providers

A clinical user or provider receiving an *Access Code* from a member of the community will need to know about the county's screening application or need a URL from the user. Training materials will be developed and provided to clinical users before the launch of the screener. The clinical user can then type in the *Access Code* at the URL and view the anonymous results along with the full set of item responses and information on the validated scales that were selected to be included in the screener questions. Downloading a full PDF of all details in a clinically acceptable format is an option. The clinical user may also choose to view "online only" and return in the future assuming that the clinical user keeps the *Access Code* and the person's identity in a secure place. Providers are not required to create an account or authenticate themselves as a member of the therapeutic community. As such, the features for

[1] We are aware that the word "Access" is also used in Monterey County to refer to MCBH's ACCESS to Treatment Clinics. The term "access code" tested well in initial user testing sessions. We plan to use this code with ACCESS clinics and other providers as long as it is not a point of confusion.

providers will be designed as transparent to community users. The value of this solution will be in the easy adoption and utilization of the screening tool.

At the Clinic Mode

A provider may choose to administer the screening to a client from within an office or clinical setting. In this case, it may not be appropriate to show a referral option, particularly to the location where the client is presently at. The At the Clinic Mode can be set at any time and will remain set for the device until deselected. The community user in a clinic who takes a screening will see a message to return the device upon completion. An option to clear results will be included.

Information Architecture

The following information will be structured into the content management database for English and Spanish languages. Many of the following record types have matured over time.

1. **Client**—each county will have its own CredibleMind client record and have a unique configuration with URL, main menu item, main page customization, and branding.
2. **Assessment**—the Help@Hand screening project will use one assessment record.
3. **Assessment results**—the Help@Hand screening project will have many assessment result records for each of the conditions as well as acuity levels for each condition.
4. **Organizations, Services, Locations**—each county will have several organizations, and each organization can have multiple services that are offered at multiple locations. This information will be used for primary referral and additional local service referral within the results of the screening tool.
5. **Topics**, **Audiences, focus Tags**—each county's organizations and services will have certain attributes that a user may view or filter. Responses to demographic questions may identify the user as being a member of a certain audience such as being in a certain age group or having a certain focus tag such as an insurance type. An organization or service can also be associated with a mental health or wellbeing topic.
6. **Site Copy**, **page Intros**—all page-level features include page copy that is structured for future modification and translation into Spanish.
7. **Self-help resources**—For each of CredibleMind's 240 mental health and wellbeing topics, there are thousands of published videos, podcasts, articles, apps, blog articles, and more available. Each resource is also audience- and focus-tagged for further filtering and presentation within results of the screening tool.
8. **Images** - Organizations, Services, Topics, Assessments and Self-help resources all include images that are managed at the site-wide level.

Upcoming changes to Functional Design Document

As of May 11, 2022, CredibleMind has an unresolved change order request. If approved, this design document will serve as an initial draft and an updated version will be submitted by September 12, 2022.

4.1 Draft of Screening Questions

1. Summary

CredibleMind is able to deliver an initial version of the comprehensive web-based mental health screening application based on known requirements. These known requirements, according to the statement of work, include conditions outlined in the table below and demographic questions that both branch to condition subtypes if relevant to the user and assess social determinants of health.

The full draft of screening questions in English and Spanish can be found as an additional upload in Appendix C. Additional supplementary material to support the screener development can be found as an upload in Appendix D. This table shows a summary of conditions, scales, and number of questions:

Condition	**Scale**	**Minimum # of questions**	**Maximum # of questions**
Depression	Two questions of the 4-item Patient Health Questionnaire (PHQ-4), with branching into the 9-item Patient Health Questionnaire (PHQ-9)	2	9
Anxiety	Two questions of the 4-item Patient Health Questionnaire (PHQ-4), with branching into the 7-item Generalized Anxiety Disorder scale (GAD-7)	2	7
Postpartum depression	EPDS (Edinburgh Postnatal Depression Scale)	0	10
Trauma/PTSD	PC-PTSD-5 (Primary Care PTSD Screen for DSM-5)	1	6
Bipolar and Psychosis	WERCAP (Washington Early Recognition Center Affectivity and Psychosis Screen)	16	28
Substance use disorders	TAPS (Tobacco, Alcohol, Prescription medication, and other Substance use) for users 21-years-old and older	5	31
	CRAFFT (Car, Relax, Alone, Forget, Friends, Trouble) 2.1+N (Nicotine) for users 20-years-old and younger	5	20
Plus 12 demographic questions			
TOTAL for non-pregnant youth		**38**	**82**
TOTAL for non-pregnant adult		**38**	**93**

Use cases that result in different question ranges

- For users at risk of anxiety or depression, there are an additional 5 and 7 questions, respectively.
- For a pregnant youth or adult, there are an additional 10 questions.
- For users who affirm that they have experienced a traumatic event, there are an additional 5 questions.
- For users at risk of bipolar or psychosis, there are an additional 3 and 8 questions, respectively. Additionally, there is 1 supplemental question that asks about substance-induced affective or psychotic symptoms.
- For substance use (21+), there are up to 26 additional questions depending on how many and which substances are being used.
- For substance use (<21), there are up to 15 additional questions depending on how many and which substances are being used.

Upcoming changes to draft of screening questions

As of May 11, 2022, CredibleMind has an unresolved change order request. If approved, the current draft of screening questions will serve as an initial draft and an updated version will be submitted by September 12, 2022.

4.2 Design Sprint

1. User Personas

The following user personas were identified to create the main workflows for the prototype.

Persona Summary	User Role	Technology	Language / Access	Age Range (16+)	Concern	Result	Method
Applicant on smartphone with Concern, English speaking	Services applicant	SmartPhone Only	English speaker	Young Adult	Anxious, can't focus	Concern with Anxiety	Online
Applicant on smartphone with No Concern, Spanish speaking	Services applicant	SmartPhone Only	Spanish preferred/ only	Adult	Impulsive Behavior	No Concern	Online
Applicant on desktop with Concern, English speaking	Services applicant	Desktop	English speaker	Senior	Depressed	Concern with Depression	Online
Applicant on desktop for someone else, Spanish speaking	Loved One on behalf of End User	Desktop	Spanish preferred/ only	Adult	Not Lucid	Concern with Psychosis	Online
Applicant on desktop for self, hearing impaired	Services applicant	Desktop	Hearing Impaired	Adult	Addiction	Concern with Addiction	Online
Applicant on desktop for someone else, other language	Loved One on behalf of End User	SmartPhone Only	Indigenous oral tradition only	Adult	Grief/ Trauma/ PTSD	Concern with Trauma	Online
Applicant walk-in on iPad for self, English speaking	Admin Assistant sets up End User	Clinic iPad	English speaker	Adult	Substance Use	Concern with Substance Use	In Clinic Walk In
Applicant call-in, admin on desktop, English speaking	Admin Assistant on behalf of End User	Clinic Desktop	Sight Impaired	Adult	Depressed	Concern with Depression	In Clinic Over Phone

Behavioral Health Staff on desktop	Clinical User recipient of Services Application	Desktop	English speaker	Adult	Access to PDF	Downloads PDF	MCBH ACCESS uses MyAvatar from ntst.com (NetSmart)
County Admin on desktop	Admin User of County Site	Desktop	English speaker	Adult	Access to admin tools	Adds or edits resources	Online
Help at Hand Admin	Admin User of All Sites	Desktop	English speaker	Adult	Access to admin tools	Adds or edits users, resources	Online

County Stakeholder	Receives Reporting/ Insights	Desktop	English speaker	Adult	Access to Reports	Views reports	Evaluates Program through reports
Help at Hand Stakeholder	Receives Reporting/ Insights	Desktop	English speaker	Adult	Access to Reports	Views reports	Evaluates Program through reports

2. Onboarding Prototype

The full workflow prototype for user testing is a dynamically updated mockup of screens to help communicate workflow and user experience. CredibleMind uses a software called InVision to design mockups and test out workflows and prototypes. All user personas and workflows are represented with detailed emphasis on feature gaps including referral workflows. Key onboarding features include:

1. A primary call-to-action to start screening in English or Spanish
2. Option to view *Need Help Now* resources
3. Option to view *Frequently Asked Questions*
4. Option to *Sign Up* and *Create an Account*
5. Option to retrieve a prior result anonymously via an Access Code

Onboarding and application prototypes are being dynamically updated. There is a slide deck with screenshots that serves as a record of the user testing version (Appendix E as additional upload). To access the onboarding and application prototypes in responsive screen widths, follow these links:

Desktop: https://crediblemindfeedback602374.invisionapp.com/console/share/NFX4VZUQEWA iPad: https://crediblemindfeedback602374.invisionapp.com/console/share/YSBJT6F9PQN iPhone:

https://crediblemindfeedback602374.invisionapp.com/console/share/PWTDUCQKXE4

3. Application Prototype

Using the same onboarding prototype workflows as above, the application prototype represents a sample of screener questions and the following results scenarios. Please see the live platform for a complete user experience of branching questions.

The following key application and referral process features include:

1. Guidance to user taking Screener for self or on behalf of someone else
2. Branching and adaptive Screener questions including demographics collection
3. User results categorized by levels of concern per result scale segmentation
4. User referral guidance to primary behavioral health agency and also to other local resources
5. Segmentation of referral guidance by age range, insurance type and other factors

6. Prioritization of referral locations by user detected location or specified city
7. Anonymous or signed in user option to share an Access Code to retrieve anonymized results
8. User option to create an account and save results to a user profile
9. Users with account created may have results emailed to them
10. All users may download results

4. Prototype of Ability for Provider to Access User Results

To ensure that providers do not need to be authenticated and credentialed, all provider functionality is offered within the main workflows. Please reference the links above under Onboarding Prototype. Key features include the following:

1. An *At the Clinic* mode uses appropriate prompts to users at the end of a screening
2. *View Clinical Result*s options are offered from the home screen and from specific results
3. Provider can receive an Access Code from a user who has taken the screening and view anonymized results
4. Clinical Results include user item responses and validated scale information
5. Clinical Results PDF may be downloaded for upload into an EHR

5. Live Platform Configuration with Questions

The live working configuration is now available on the CredibleMind platform. It includes features marked "not a feature gap" in the Business Requirements (Appendix A in this document). It also includes the complete draft set of screening questions. Key functionality includes:

1. A primary call-to-action to start screening in English or Spanish
2. Option to view *Need Help Now* resources
3. Option to view *Frequently Asked Questions*
4. Option to *Sign Up* and *Create an Account*
5. Answer screener questions on behalf of self
6. Placeholder questions and results (screener does not represent final

set of questions) To access the live platform configurations, follow these

links:

Test Site in Production Environment: testmonterey.crediblemind.com
Test Site in Staging Environment: cm-staging.netlify.app/?brand=testmonterey

Upcoming changes to prototypes and live platform configuration

As of May 11, 2022, CredibleMind has an unresolved change order request. If approved, the prototypes in this deliverable will serve as initial versions and updated versions will be submitted by September 12, 2022.

4.3 User Testing

1. User Testing Script

The CredibleMind Design team completed five virtual user testing sessions in English with residents from Monterey and neighboring Santa Clara Counties for the first round of user testing. The sessions were conducted from April 28 - May 5, 2022. For this first round, we chose to test the initial workflow, homepage, and results designs. Testing sessions lasted approximately 30 minutes each, and participants were reimbursed with a $25 gift card. Our Design team conducted testing using the script located in this document in Appendix B while showing prototype designs via InVision.

2. Summary of User Testing Findings

All five users found the screening to be of interest and the workflow to work well. The confirmatory findings were as follows:

1. Users appreciated the visual appeal of the initial home page.
2. Users appreciated the option to start the screening process in Spanish (some users were bilingual and non-Spanish speakers also commented on the value of this option).
3. Users confirmed they are generally willing to answer the questions that were posed as representative of the entire screening tool.
4. Users understood the summary of their results displayed by levels of concern. Some showed interest in learning more about the various conditions.
5. Users understood conceptually that in addition to viewing results they could be directed to services and they had an appreciation for the overall concept of being guided to services.

The key findings and mitigations were as follows:

1. **Home page** - Ability to enter an access code confused one user. “Do I need an Access Code to access the screener?”
    a. *Mitigation* - The developed version will have Access Code section text changes for retesting.
2. **Sample question Likert format** - Likert-scale questions appearing in varying orders is more confusing to some users. One commented on the varying order and another commented on the design layout not being as friendly as radio buttons. If validated scales offer flexibility, consistency is preferred. A stakeholder also mentioned that Likert-scales may not resonate for various user groups.
    a. *Mitigation* - Continued research and further testing should reveal the best design going forward.
3. **Sample questions context** - users commented that they desired to know why they are being asked certain demographic questions.
    a. *Mitigation* - The final design includes a plan for better context and

descriptions for retesting.

4. **Referral calls to action** - users were confused by the QR Code option for accessing results. Users asked again what they should share on a call or bring when they walk in.

    a. *Mitigation* - A new design without a QR Code and with better instruction text may focus users on their next steps and can be retested.
5. **Results options** - users prefer to have results emailed to them. The results page was suggested as the primary time to request sign-up vs upon question completion before seeing results.
    a. *Mitigation* - The submit button order should be changed based on this feedback.
6. **Results detail** - users expressed an interest in learning more about each condition and their scores. The results sections may include self-care resources and, based on interest, may be better presented without a collapsed accordion.
    a. *Mitigation* - These options are configurations and can be retested.
7. **Hours and locations** - users like this feature and requested that location be optionally detected vs entered. Users want links to Google Maps. Users also want to have access to a phone number.
    a. *Mitigation* - Development plans to include user location detection and research on Google Map linking are underway. Mockups now include a phone number.

Upcoming changes to user testing

As of May 11, 2022, CredibleMind has an unresolved change order request. If approved, additional testing will be conducted. We plan to conduct user acceptance testing with clinicians as well as usability testing of the workflow on our live platform with English- and Spanish-speaking users. Summary of findings of additional testing and updated scripts in English and Spanish will be submitted by September 12, 2022.

4.4 Refinement and Estimated Completion Time

1. Refinement Process

We have been able to refine the screening application based on user testing findings as well as initial feedback from stakeholders to whom we've presented in meetings. Some of these mitigations are outlined above. Here is a full summary of refinements we have made so far:

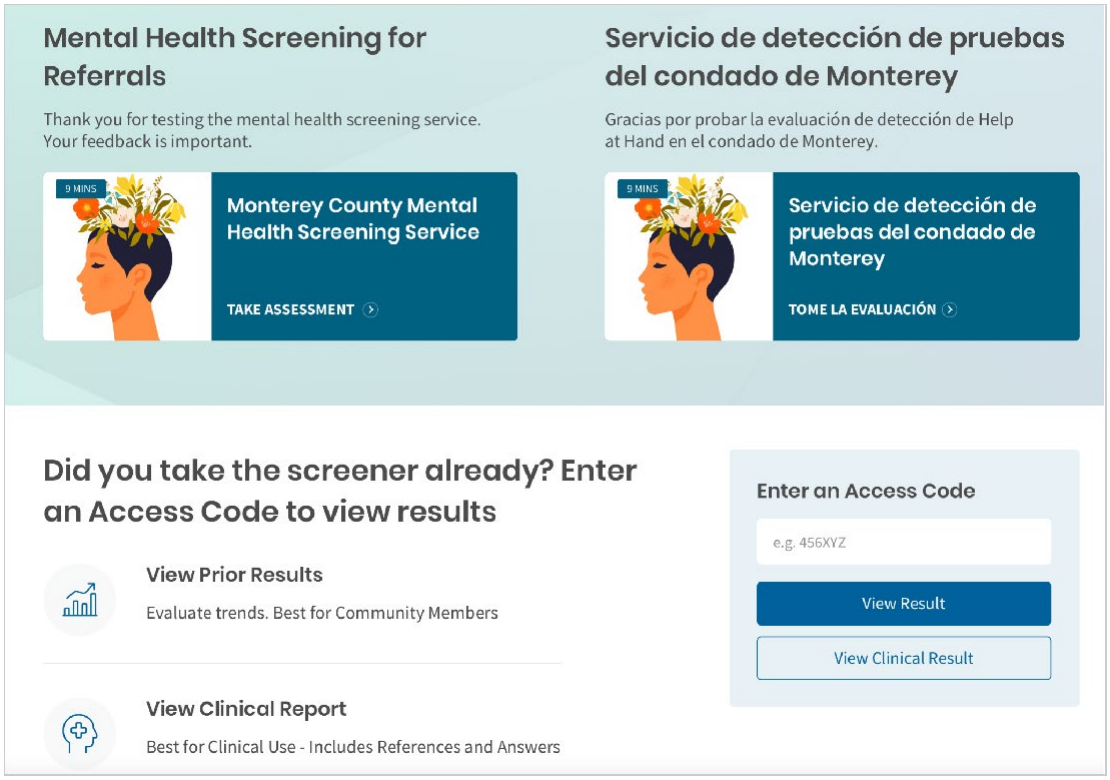
- We added context to question descriptions so users know why they are being asked certain demographic questions. This change will be made directly on the live platform. Users will see an explanatory subtitle on

  > **The next set of questions may feel sensitive or strange to answer. We ask these questions to everyone who takes this screener in order to get the most complete picture of your mental health. Please be as honest as possible. As a reminder, your responses are private and anonymous unless you choose to share them.**

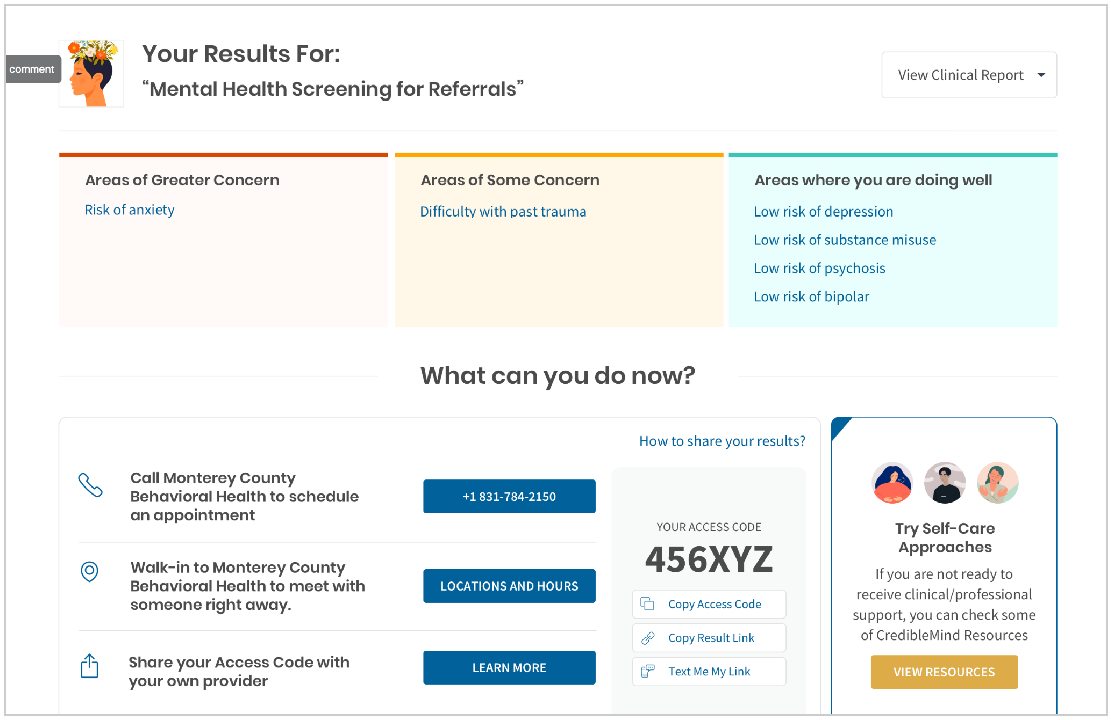
  any question that requires it.

- The results page was suggested as the primary time to request sign-up vs upon question completion before seeing results. The submit button order will be changed on the live platform based on this feedback.

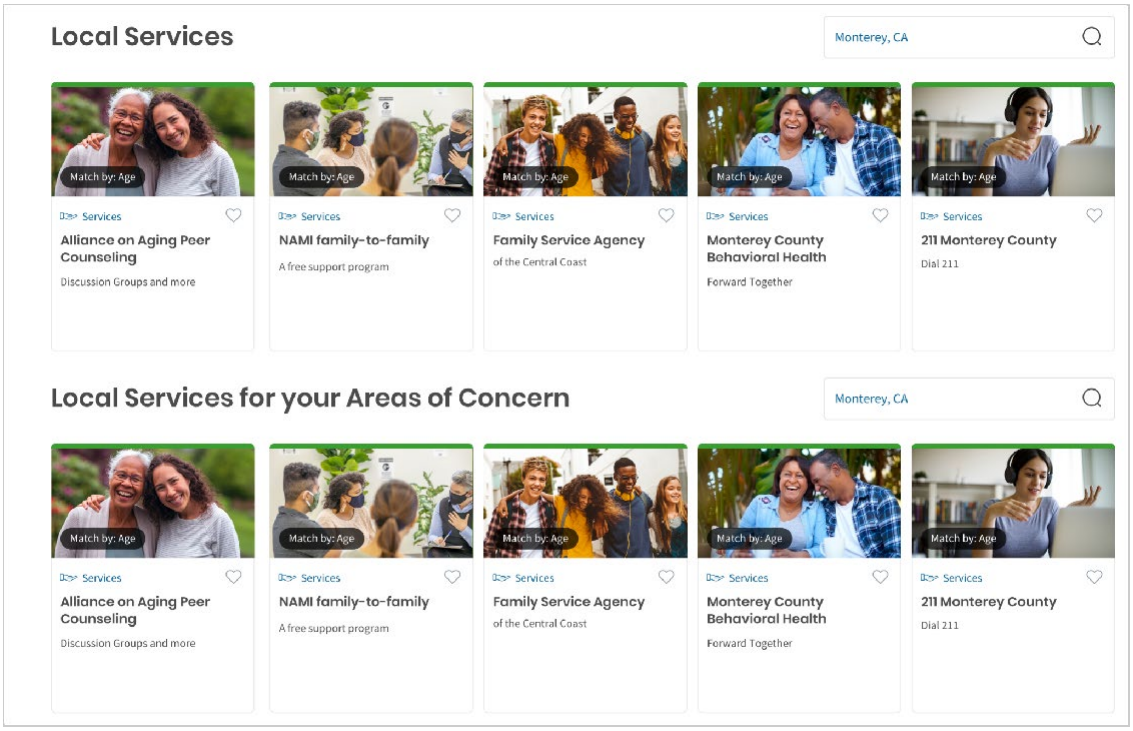
- During testing, users were confused by the option to enter an Access Code on the first view. Text was updated to make it clear that the second section is for prior results.



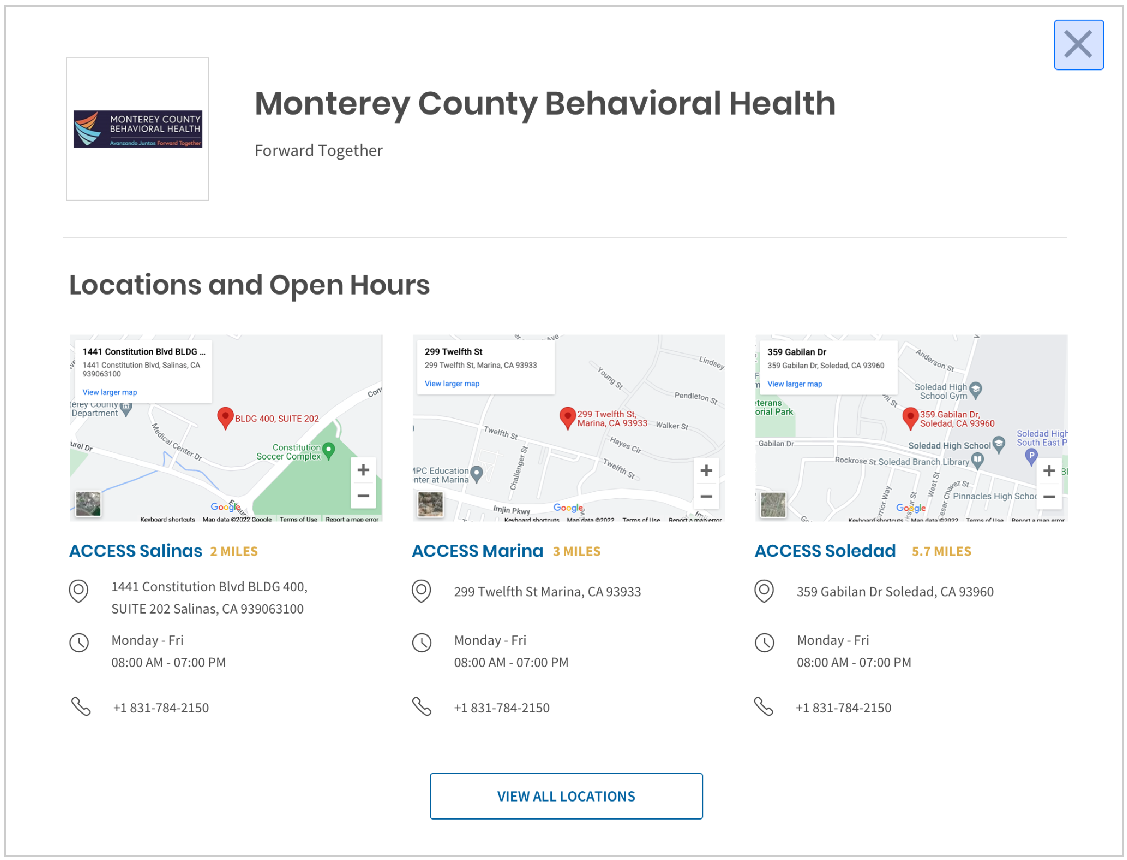
- The Access Code section text and option to scan a QR code were confusing to users. Text and options were changed to only include copying the Access Code, the link, or texting the link. Further refinement of site copy is under review.



- The Services now include the option of displaying multiple lists of resources. Each user may match to a higher number of services. The matching rules labels (i.e. "Match by Age") was appreciated during user tests.



- The Hours and Locations for an Organization or a Service has been updated to include phone numbers based on user feedback.



2. Estimated Completion Time

CredibleMind offers assessments to users of varying lengths. The assessment most similar in question length to the proposed screening tool is taking the majority of 1200 assessment takers 10-12 minutes to complete.

This estimated amount of time to complete is confirmed by initial testing of the English version via our survey platform in desktop mode. Based on our initial findings, we estimate the screening tool to take 5-6 minutes to complete for the minimum number of questions and 10-15 minutes to complete for the maximum number of questions. We plan to continue refining the completion time using our live platform on all devices (i.e. desktop, smartphone, tablet), with all use cases, and in both English and Spanish.

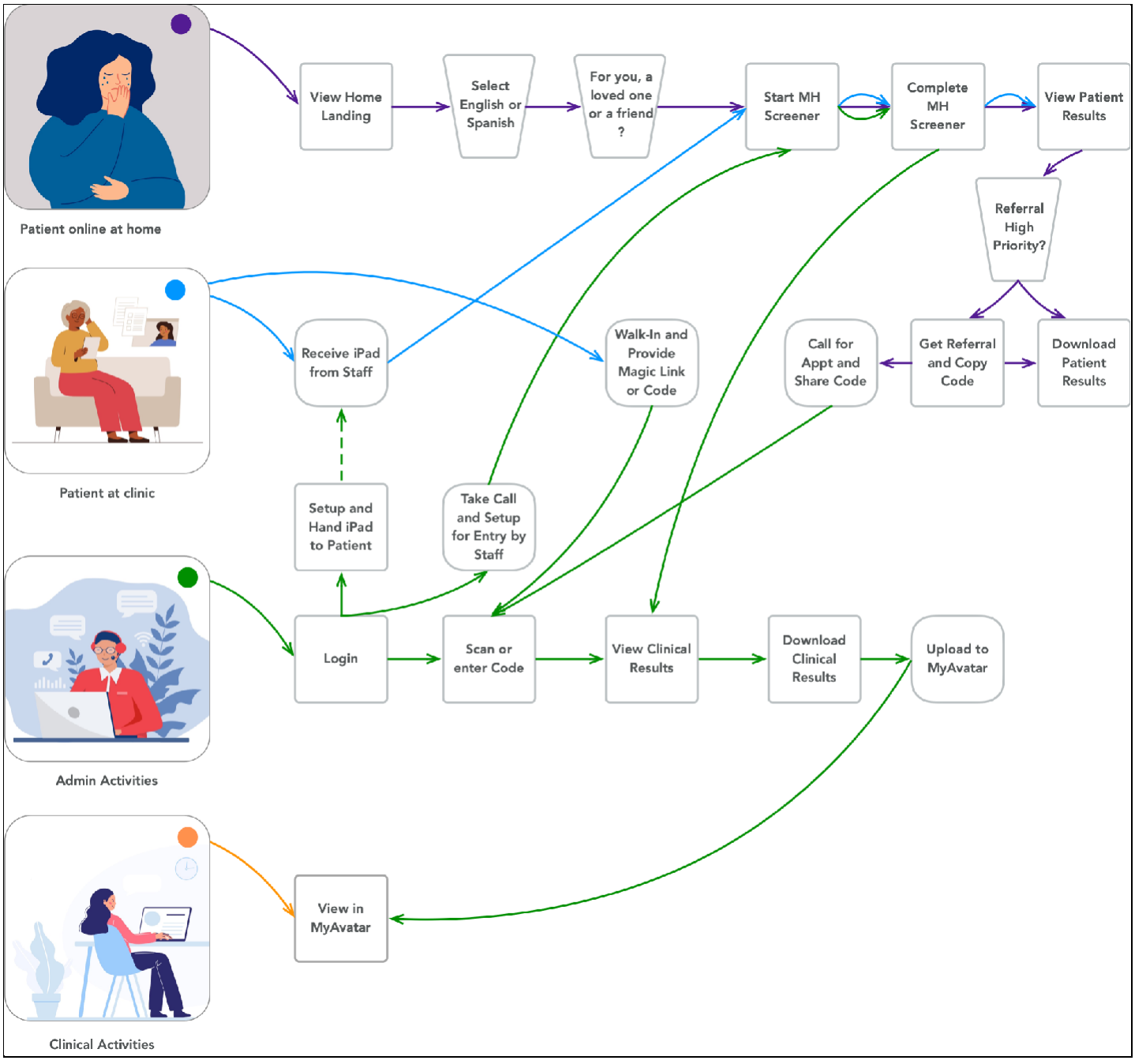
Upcoming changes to refinement process and estimated completion time

As of May 11, 2022, CredibleMind has an unresolved change order request. If approved, additional refinement of the screening tool will be conducted. Throughout the remainder of the project until launch, we will continue to share updates to the prototypes and demo new and improved features of the live platform to stakeholders. A finalized estimated completion time will be determined using our live platform and submitted by September 12, 2022.

Appendix A

Milestones: User Journeys and Business Requirements

The following user journeys and business requirement analysis informed the application prototypes and will continue to guide the development tasks.



Business Requirements Analysis

Workflow Order	Category	Business Requirement	Feature	Feature Gap	Status
1	Site Instance	Each county has an instance of the site.	Configurable instances	No	Feature Ready
2	Site Instance	Instance is available in English or Spanish.	Support Spanish Content	No	Feature Ready
3	Onboarding	User sees a bilingual intro to the assessment	Bilingual home hero section	No	Feature Ready
4	Onboarding	User language is set when user selects screener language.	In flow language setting	No	Feature Ready
5	Onboarding	User can access emergency services info.	Need Help Now page	No	Feature Ready
6	Onboarding	User can learn about the project and what to expect.	Questions page	No	Feature Ready
7	Onboarding	User understands who can use the screener and what to expect.	Home Intro	No	Feature Ready
8	Assessment	User is addressed according to role (for self or someone else).	User pre-assessment question and text	Yes	Actionable - In Process
9	Assessment	User can take assessment in English or Spanish.	Support Spanish Assessment Content, a toggle to change between languages	No	Feature Ready
10	Assessment	User sees assessment adapt based on previous compilations of answers.	Adaptive assessment	Yes	Actionable - In Process
11	Assessment	User sees replicated questions suppressed or filled in.	Standardized question set	Yes	Actionable - Defined
12	Assessment	User can take assessment on an agency's tablet for the agency	User can select At the Clinic for workflow	Yes	Actionable - Defined
13	Results	User and clinical score notations meet workflow needs.	Results View	Yes	Actionable - Defined

14	Referral	User is provided clear referral instructions for key agencies if areas of concern	Highlighted referral options	Yes	Actionable - Defined
15	Referral	User is provided with broader options if no areas of concern	Highlighted self-care options	Yes	Actionable - Defined
16	Referral	User is provided with guidance to hand back	Highlighted return device message if At	Yes	Actionable - Defined

		device if in clinic	the Clinic is selected		
17	Results	User can download a PDF report of results summary info.	Results Report PDF	Yes	Actionable - In Process
18	Results	Clinical user views clinically oriented reports	Clinical Results View	Yes	Actionable - Defined
19	Results	User can download a PDF report of questions and answers.	Clinical Report PDF	Yes	Actionable - Defined
20	Results	User has option to access anonymous results later via QR Code, confirmation code or magic link.	User Access Code	Yes	Actionable - Defined
21	Authentica tio n	User can receive a text with the magic link/access code.	Request Text with Link	Yes	Actionable - Defined
22	Authentica tio n	User has option to create an account to access results later.	Various Sign In options	No	Feature Ready
24	Resources	User sees virtual resources for self-help, etc. related to results.	Display Self-Help Resources per Condition	No	Feature Ready
25	Resources	User sees filtered resources near them.	Display Services by Location	Yes	Actionable - Defined
26	Resources	User sees filtered resources for their insurance type or age range.	Display Services by insurance or age range	Yes	Actionable - Defined
27	Search	User can search for and find resources related to results and does not find any excluded resources.	Client configured search	Yes	Actionable - Defined

28	Admin	Project User can manage configurations for all instances.	Admin Tools - Resources	Yes	Actionable - Defined
29	Admin	Project User can manage roles for designated county admins.	Admin Tools - Users	Yes	Actionable - Defined
30	Admin	Project or County Admin User can manage configurations for one community instance.	Client Admin Tools	Yes	Actionable - Defined
31	Satisfaction	Users can provide satisfaction measures in form of Was your Site Visit Helpful or Assessment Helpful	User Satisfaction Surveys	No	Feature Ready

Appendix B: User Testing Script

Hello. Thank you for taking the time to provide feedback on our preliminary designs for the new Monterey County Behavioral Health Self-Screening Tool. This online quiz will let people know which mental health conditions they may be at risk for and provide recommendations of resources and referrals. This session will take 30 minutes. We will be showing you designs and please provide your honest feedback of what you like, what could be improved, and if there is anything you would change.

Show Invision #9
Part 1: What do you think this screening tool/quiz would show? Is this how you would like to be shown two different language options?

Part 2: What do you think about the guest code feature? What do you think it would do?

Show Invision #10
Do you think you would take the screening tool/quiz for someone else? When would this occur?

Show Invision #12
What do you think about the length of the tool/quiz? What do you think about the layout of the questions? Are there any questions that you do not feel comfortable answering? Are there any questions that you do not understand why we are asking?

Show Invision #13
Do you think you are more likely to click sign up or sign in as guest? Why?

Show Invision #14
What do you think about the results for the mental health screening tool/quiz for referrals? Do you find this page useful?

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What would you like resources based on? Your demographics, interests or a combination of both? What, if anything, would you do next after looking at your risk scores? Would you be interested in downloading results? Why or why not? Would you email the results to yourself? Why or why

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8.0 Technical Documents

JUNE 30, 2022

The following pages include summaries and required deliverables for 8.0 Technical Documents for the Help@Hand screening application project. All parts are listed in the Table of Contents below.

Table of Contents

Business Requirements and Functional Design Documents

Business Requirements and Functional Design Documents were submitted as part of the 4.0 Functional Design Document deliverable on May 11, 2022 and approved on May 11, 2022. Documents can be delivered upon request.

Technical Design Document

Introduction to Technical Design

After completion of a Functional Design Document, CredibleMind has moved on to document the technical design of the solution for the Help at Hand Screener for Referrals. At a high level, CredibleMind offers configurable software as a service. For this project, all configurations will be grouped into Help at Hand for the purposes of supporting a standardized screening assessment, administration and reporting. For each county that chooses to engage, an instance with a unique subdomain will be created and unique local organizations and services along with key messaging will be configured based on a service mapping review process.

Technically, we will answer how we do this and how another technical team may do this in the future in the unlikely event that the relationship between Help at Hand and CredibleMind terminates.

Change Request Impact on Technical Design Document

As of May 11, 2022, CredibleMind has an unresolved change order request. If approved, this design document will serve as an initial draft and an updated version will be submitted by September 12, 2022.

1. Themes and Features

The Feature Gap analysis matrix includes themes and features. Some features are currently in production and can be configured or edited to achieve the workflow. These features are listed with Feature Gap is No. All other features are considered deliverables during the Application Development phase. These features are listed with Feature Gap is Yes.

Theme	Business Requirement	Feature
Site Instance	Each county has an instance of the site.	Configurable instances
Site Instance	Instance is available in English or Spanish.	Support Spanish Content
Onboarding	User sees a bilingual intro to the assessment	Bilingual home hero section
Onboarding	User language is set when user selects screener language.	In flow language setting
Onboarding	User can access emergency services info.	Need Help Now page
Onboarding	User can learn about the project and what to expect.	Questions page
Onboarding	User understands who can use the screener and what to expect.	Home Intro
Assessment	User can take assessment in English or Spanish.	Support Spanish Assessment Content, a toggle to change between languages
Assessment	User sees assessment adapt based on previous compilations of answers.	Adaptive assessment
Results	User can download a PDF report of results summary info.	Results Report PDF
Assessment	User is addressed according to role (for self or someone else).	User pre-assessment question and text
Assessment	User can take assessment on an agency's tablet for the agency	User can select At the Clinic for workflow
Referral	User is provided clear referral instructions for key agencies if areas of concern	Highlighted referral options
Referral	User is provided with broader options if no areas of concern	Highlighted self-care options
Referral	User is provided with guidance to hand back device if in clinic	Highlighted return device message if At the Clinic is selected
Results	User has option to access anonymous results later via confirmation code or magic link.	User Access Code
Notification	User can receive a text with the magic link/access code.	Request Text with Link
Assessment	User sees replicated questions suppressed or filled in.	Standardized question set
Results	User and clinical score notations meet workflow needs.	Results View
Results	Clinical user views clinically oriented reports	Clinical Results View
Results	User can download a PDF report of questions and answers.	Clinical Report PDF
Authentication	User has option to create an account to access results later.	Various Sign In options
Resources	User sees virtual resources for self-help, etc. related to results.	Display Self-Help Resources per Condition
Resources	User sees filtered resources near them.	Display Services by Location

Resources	User sees filtered resources for their insurance type or age range.	Display Services by insurance or age range
Search	User can search for and find resources related to results and does not find any excluded resources.	Client configured search
Admin	Project User can manage configurations for all instances.	Admin Tools - Resources

Admin	Project User can manage roles for designated county admins.	Admin Tools - Users
Admin	Project or County Admin User can manage configurations for one community instance.	Client Admin Tools
Satisfaction	Users can provide satisfaction measures in form of Was your Site Visit Helpful or Assessment Helpful	User Satisfaction Surveys

2. User Stories and Acceptance Criteria per Feature

CredibleMind uses design sprints to determine workflows which are visualized into mockups. The user workflow mockups have been through two rounds of user tests and have been reviewed by clinical stakeholders. Most workflow concerns have been resolved down to cosmetic and text level changes. With this said, the product team is following an agile process and can continue to be responsive to new findings. For all new functionality, each feature has a series of user stories and acceptance criteria as follows:

Feature	User Stories	Acceptance Criteria
Adaptive assessment	As a user I want to answer screener questions as efficiently as possible so I can get results quickly.	1. User sees branching questions only if they are required for the user to answer based on a prior question. 2. User sees branching questions based on the sum score of previous answers only when the user meets a min or max score. 3. User sees an immediately revealed branching question when context is important, for instance, the question is a follow-up. 4. User sees a delayed reveal of additional questions when the score from a series of questions determines the additional questions required. 5. User sees numbered question updates as questions are added for better context.
Results Report PDF	As a user I want the option to download my results so I can keep a record.	1. User sees a Download button on the results page. 2. When the user clicks Download a PDF is generated and downloaded without any additional steps required. 3. The user sees all key elements of the results excluding any submit buttons to other pages of the site. 4. Links are active on key links so that the user can go back to the site from the PDF.

User pre-assessment question and text	As a user I want to know the difference between my own results and the results I complete on behalf of someone else so I can review them later in my profile.	1. User can select an option to complete the screener for self or someone else. 2. Screeners completed for someone else are not displayed in the user's view of assessments if the user has created an account.
User can select At the Clinic for workflow	As a user at a clinic working with a client I want to hand them an iPad and ask them to take the screener so I can facilitate completion.	1. User can view an At the Clinic button from any menu header. 2. User can select the At the Clinic button and leave it on for any device across multiple sessions.

Highlighted referral options	As a user I want to know what I can do based on my areas of focus and concern so I can take my next step and refer myself.	1. User sees referral instructions based on levels of severity if At the Clinic is off. 2. Each county instance has varying referral instructions based on levels of severity. 3. User sees special referral instructions and messaging if under 16. 4. User sees special referral instructions and messaging if qualifying for Beacon EAP through a combination of severity and the user has Medi-Cal according to their insurance type answer.
Highlighted self-care options	As a user with lower areas of concern for all focus answers I want to see special instructions for considering my next step so I can refer myself if I prefer.	1. User sees a full panel layout of areas of concern with only the lower area of concern displayed. 2. User sees instructions about determining whether to refer oneself to services.
Highlighted return device message if At the Clinic is selected	As a user at a clinic working with a client I want to receive the iPad with the Access Code on the screen so I can use my EHR computer to download results and upload into their chart so we can reference it going forward.	1. User taking the screener can see a message to return the device with Access Code displaying instead of the typical highlighted referral instructions in results if At the Clinic mode was set to on.

User Access Code	As a user who has taken results, I want to see an access code and copy it or the full link so I can access my results later. As a user who has stored an access code I want to go back to a site and enter my access code later so I can view results. As a user who has stored a full link I want to click it so I can view my results online . As a user I want to know how to securely share my access code or a link with providers so I can get informed help.	1. User can enter an access code for any result and view it. 2. User taking a screener can view a result with an access code and may or may not have signed up during the prior screening workflow. 3. User can copy a full link and click it later to view results. 4. User is informed on how to keep their results secure when sharing their access code with providers.
Request Text with Link	As a user I want to request that a full link be sent to my phone via text so I can use the text to access my results later.	1. User can enter a mobile number and receive a text with a full link.
Standardized question set	As a user I don't want to answer questions more than once so I can complete the screener quickly.	1. User will only see questions that are unique based on time interval and wording. Note: this is waiting final review but may not require new functionality.
Results View	As a user viewing the screener I want to know the areas of concern that I have based on my answers. As a user viewing the screener I want to learn more about each area of concern so I can understand my options.	1. Any user completing an assessment or entering an access code will arrive at the patient results view. 2. User sees a summary view with scores categorized into three segments: Greater Area of Concern, Moderate Area of Concern and Lower Area of Concern. Exact language may change to match referral and treatment levels. 3. User may also see scores in clinical scale or standardized scale

		(0-100 scale).
Clinical Results View	As a user viewing the screener I want to know the scales used so I can understand the process. As a user viewing the screener results I want to know the patient's answers so I can review key questions. As a user viewing the screener results I want to know how the patient scored for each problem area so I will know how to treat them. As a user viewing the screener results I want to know when it was taken so I can understand if	1. Any user can view the clinical view of the results by clicking the Clinical View button. 2. User sees a summary view with similar patient results with scores in validated scale segments and worst to best order. 3. User may also see scores in standardized scale as a supplement if presented to the user in the Patient Results view (0-100 scale). 4. The clinical view has a per problem area with intro text displayed to patient 5. The clinical view has all the patient answers per problem area 6. The clinical view has the scale origin and scoring rules 7. User sees any guidance provided to the patient at the time they took the screener. 8. Links back to the Patient View are active.

	it's recent enough.	
Clinical Report PDF	As a user I want to download the complete clinical report so I can upload it into an EHR associated to the patient.	1. The user sees a Download Clinical Report button. 2. The PDF includes a full clinical view ordered by priority of content with patient scores per problem area first, patient answers and then validated score reference content that does not change per result. 3. Links back to the Clinical View are active.
Display Services by Location	As a user I want to know where services are offered so I can go to the most convenient location for me.	1. User sees all applicable services in card views under results. 2. User can allow detection of current location and see services nearest first. 3. User can deny detection of current location and see all services for the county. 4. User can select a city that may differ from current location and see all services nearest to the city first.
Display Services by insurance or age range and by priority	As a user I want to see services that are relevant to me so I can select one.	1. User with an age range will not see any services only offered for other age ranges. 2. User with an age range that matches services will see a matches your age label on the resource card if the service is offered for their age range. 3. User with an insurance type will not see any services only offered for other insurance types if appropriate. Note that most services accept all methods and filtering may not be advised. 4. User with an insurance type that matches services will see a matches your insurance label on the resource card if the service is offered for their insurance type. 5. User with a binary gender may not be required to view the opposite binary gender services if appropriate.
Client configured search	As a user I want to see services by name if I search for them.	1. User can search for services by name using the search box.
Admin Tools - Resources	As a user that administers the help at hand project I want to view user traffic and aggregate statistics so I can have insight.	1. User can view user traffic reports per county 2. User can view aggregate screener results stats per county 3. User can switch counties or view all in county. Note: Will use current reporting framework and UX.

Admin Tools - Users	As a user that administers the help at hand project I want to assign county users access rights so I can involve	1. An admin user can grant access for all Help at Hand users and for client admin users.

	them.	
Client Admin Tools	As a user that administers county services and organizations, I want to keep them up to date so I can direct referrals properly.	1. User can submit a form request for updates. 2. User can self serve edit key resources from a client admin portal. Note: Will expand use of current Client admin resources tools to include more resource types.

3. Confirmed and Elaborated User Workflows

Since the initial user tests were conducted in early April, problem areas were identified, updated and retested. Final end user and clinical user journeys are represented in the following responsive workflows:

Desktop: https://crediblemindfeedback602374.invisionapp.com/console/share/NFX4VZUQEWA
iPad: https://crediblemindfeedback602374.invisionapp.com/console/share/YSBJT6F9PQN
iPhone: https://crediblemindfeedback602374.invisionapp.com/console/share/9CUJPYE6R78

4. Technical Design

CredibleMind was founded in 2018 and the technical and product founders selected a modern technical stack designed from the outset to be serverless, responsive, localized and app migration friendly.

This is a summary and key areas are described below:

Stack Level	Services	Notes
User	Google Firestore/Firebase	Anonymous and Authenticated Screener Data
Auth	OAuth, SAML, Google, MSFT, FB	Allowed or required and per service
Data	Contentful, SurveyJS	Supports localization and configuration
Front End	JavaScript and React JS, CSS	
Back End	Python	
Services	Amazon CloudFront, AWS, Netlify	
Track	MixPanel, Google Analytics	Aggregated by county instance, event details
Test	Sentry, Selenium, Browserstack	Issue monitoring and test automation

Report	BigQuery, DataStudio, Sigma	Self serve and data feed using various formats including Tableau
Availability	BrowserStack, Jenkins	
Notifications	Mailchimp/Mandrill, AWS	Email and SMS for Transactional and Results

Support	FreshDesk	User Support Requests and KnowledgeBase

The technical design supporting the screening tool, user workflow business rules and user privacy are described here. The key technical design area for this workflow is the use of a user result level Access Code for retrieval of anonymous user results.

Secure Results Workflow

Users in possession of an access code will have access to a fully anonymized set of screener results on the platform. The access code will need to be paired with personal identification. Users will be instructed in safe methods for sharing their access code with a provider. This includes sharing the access code verbally and copying a link into a secure patient portal message.

Screener Design

The screener questions, answers, branching logic and result score options are all configured with the Survey JS tool. This tool outputs a JSON file that is then combined with contentful assessment and result segment content and expressed on the front end. A copy of all JSONs to produce the screener is available.

Serverless Architecture and Backup Processes

Since CredibleMind utilizes an entirely serverless tech stack, all backup processes are maintained with redundancy through third parties. For instance, all content and media on Contentful is automatically backed up by contentful to two physically separate data centers within Amazon Web Services on two continents, using Amazon's redundant S3 service (us-east-1 and eu-west-1). CredibleMind also maintains a series of backups of the master database.

5. Data Design

Content data including page level copy is stored in the contentful system. Contentful is an enterprise serverless content management system with tables of data and relationships between them. CredibleMind manages environment instances and localization into the Spanish language from contentful. Records of key importance to each county configuration are a county level record, page copy for each page of the site and the referral messaging, organizations, services and locations that comprise the recommended referrals in the results view. These are all considered custom to each county. Records of key importance to the screener include an assessment record and multiple assessment results.

Services Content Data

The contentful database includes service related content types for Services offered by each location with fields that manage the following:

1. **Content:** Each content type includes the localized site copy fields for displaying a card or page view of the Services including a url and media.
2. **Related Content:** The Services map to one organization and to many locations.

3. **County Ownership:** The Services are restricted to the client representing the county.
4. **Filtering Criteria:** Location, Audiences, Tags, Cost Description and Topic Themes contribute to the mapping of the Services to User Location, Demographics and Assessment Result data.
5. **Audit**: Contentful manages publishing status, owner and update audit trails. See Appendix B for Services and Locations JSON structure samples in this document.

Assessment and Results Content Data

For assessments, the team uses proprietary administrative tools based on Survey.JS to create and edit an assessment JSON. The contentful database includes assessment related content types for the Assessment which has many related Assessment Result records.

1. **Content:** Each assessment includes the localized site copy fields for displaying a card or page view of the assessment intro and questions.
2. **Related Results:** Each assessment also has related assessment results that display based on a user's component scores.
3. **County Ownership:** The Mental Health Screening Assessment is restricted to participating counties.
4. **Audit**: Contentful manages publishing status, owner and update audit trails.

User Data

The user data residing in firebase is written for users creating an account or using a social sign on. Any user profile information will also be written from assessment results. An example user account appears as follows:

brand: "testmonterey"
displayName: "First Last" dob:
"[45-54]"
email:"first.last@crediblemind.co" gender:
"Female"
industry: "Working in healthcare"
insuranceType:"Medi-cal/Medicaid" role:
"user"

Anonymous users are tracked per assessment taken. User activity can be combined across multiple sessions on the same device if not private browsing. A user with an account has the added advantage of having a view history, favorited resources and past assessment results.

6. Application and System Architecture

For this project CredibleMind is using a modern browser based application architecture with all code being secure serverless functions and API's.

React Application

The front end technology is a fully browser based application — this means there are no servers involved for the app to work. Each user accessing the site gets the code delivered to their browser that than

makes secure API calls to render each page in the browser. This technology, react-js, is what powers most of the modern application frameworks.

Search and AI–based Recommendations

CredibleMind uses a search optimization service, Algolia, that includes methods for determining results based on user keywords and previous user activity. All county proprietary services are both locally filtered and client filtered to achieve the best search results.

Business Rules and Hierarchy

CredibleMind manages features and settings at the platform level, the client parent level or client level for the most flexibility. In this case, the client parent is Help at Hand and the client is each county. CredibleMind uses client parent or client level feature toggles to achieve proprietary workflows, and in most cases, they will override any standard platform level configurations. All change requests are analyzed for configuration suitability. Some examples are as follows:

- Screener Questions: Client Parent or Project Level
- Screener Results per Condition: Client Parent or Project Level
- Screener Referrals: Client Level for each county
- Services and Locations: Client Level for each county
- Self-help Resources by Topic: Platform Level
- Self-help Resource Exclusions by Topic: Client Level for each county

Please note that the ERD infers the above business logic.

Application Security

CredibleMind has extensive security policies and procedures. We can make these available upon request.

User Credentials and Authentication including Single Sign On (SSO)

For sign in processes, each county can elect to offer Google, Microsoft, Facebook and native registration processes. If desired, a county may require login to use the service. To date, county stakeholders have concurred that a primarily anonymous workflow with a unique identifier in the form of an Access Code per anonymously presented result is preferred for sensitive mental health information. Google, Microsoft and Facebook social sign-ins are seamlessly tied to additional questions for age range, gender and industry. For native registration on CredibleMind, users can create an account using an email address as a unique username and strong password. If the user forgets a password, there is an automated forgotten password workflow with a temporary link to reset sent to the user's email address.

Reporting and API Architecture

All user data including assessment results are stored and can be reported. The data is combined into a reporting optimized database in Google Big Query and then managed by date ranges and visualized using Sigma. Each client or county will have its own silo which can be combined for project reporting. Results can be associated with unique users if the user has an account. User events such as viewing an

assessment or completing can be associated across devices or by location for users that are not private browsing.

Aggregate reporting is managed for all data sensitive assessment results to ensure privacy. For instance, results detail reports are restricted to the aggregated datasets for a range that includes a significant number of results.

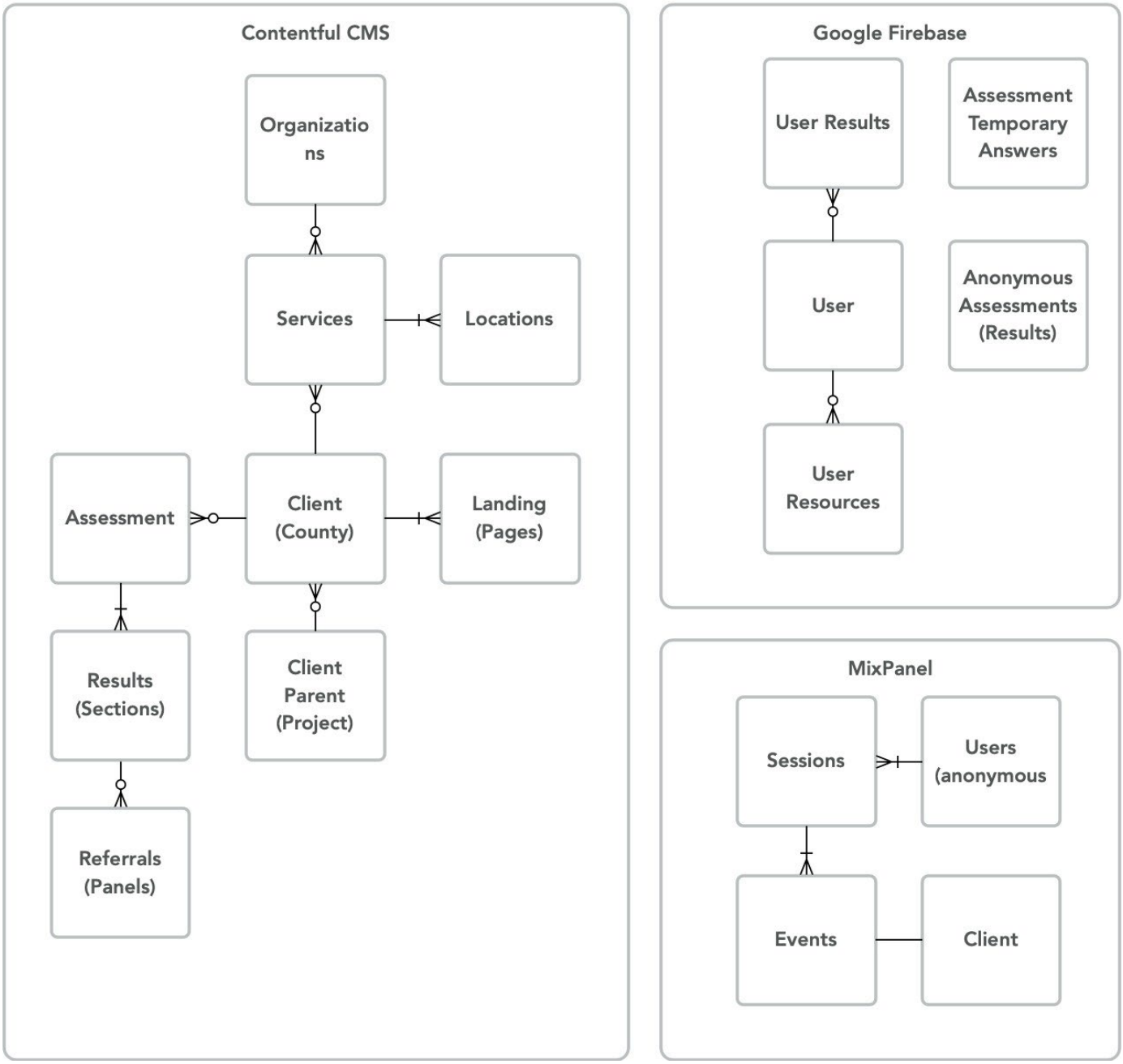
Testing Architecture

The development and quality assurance activities within the software development process include 24/7 monitoring for alerts through Sentry, a third party service which reports various error conditions with the technical detail associated to ensure the remediation of issues. Feature availability and functionality is monitored through selenium test scripts that are then automated across all supported browsers and devices using BrowserStack, a third party tool that emulates combinations of browser, OS and device for front end testing. Developers also write unit tests and monitor for issues within builds.

7. Entity Relationship Diagram (ERD)

The data ecosystem includes Google Firebase for user data, the Contentful content management system and Mixpanel events for reporting. These primary datasets are combined into Google BigQuery for the purpose of generating reports. *Please note that Self-help resources and measures of satisfaction were removed from this diagram for the purpose of focusing on the primary workflow.*

CredibleMind Help@Hand Screener Project
Entity Relationship Diagram



The relationships across data systems are maintained through consistent use of client identifiers and slugs as unique identifiers. For instance, the assessment taken from the contentful database, the firebase assessment results and the assessment completed event all share the same client brand and slug. Data Models of Assessments, Results, Services, Locations and Users are listed within this document.

8. Data Dictionary

Google Firebase User Data

The Google Firebase Realtime Database is a cloud-hosted database. Data is stored in JSON and synchronized in real time to every connected mobile or other client. It lets developers build rich collaborative applications, with data also persisted locally, to give users a responsive experience. Samples are included for user data. A full data dictionary can be generated if requested.

Contentful Content Management Data

The Contentful Content Database is a cloud-hosted database as well. Data is also stored in JSON and synchronized in real time. Sample data dictionary details are located in Appendix A for Assessments and Appendix B for Services and Locations. A full data dictionary can be generated if requested.

9. HIPAA, PHI and FedRamp Compliance

CredibleMind does not receive PHI from any covered entity to implement any workflows and are not acting as Business Associates under HIPAA. However, we are following HIPAA and PHI best practices for security and privacy. Please see the HIPAA and other policies in our Info Sec policies which have been uploaded separately and can be emailed upon request.

As a serverless architecture, the CredibleMind platform uses the following Federal Risk and Authorization Management Program (FedRamp) compliant cloud service providers for data storage and meet FedRamp Moderate standards at the locations used by CredibleMind.

Amazon Web Services

AWS US East-West (Northern Virginia, Ohio, Oregon, Northern California) has been granted a Joint Authorization Board Provisional Authority-To-Operate (JAB P-ATO) and multiple Agency Authorizations (A-ATO) for moderate impact level. The services in scope of the AWS US East-West JAB P-ATO boundary at Moderate baseline security categorization can be found within AWS Services in Scope by Compliance Program. See also: Amazon Web Services (AWS) FedRamp Policy.

Google Cloud

Google Services including Firestore/Firebase and BigQuery meet FedRamp High and Moderate standards. See the Google Cloud FedRamp Compliance Statement.

Third–Party Assessment

Third-party assessment and audits for SOC-2/3 compliance are conducted by both Google Cloud and Amazon Web Services. Google cloud audit reports are available here and AWS cloud audit reports have been uploaded separately. We also use Qualys to conduct routine 3rd-party vulnerability and penetration testing. The latest Qualys test has been uploaded separately. We will continue to have the 3rd-party scans run as we complete the development and have a final application for testing.

10. Application Workflow

The full workflow prototype for user testing is a dynamically updated mockup of screens to help communicate workflow and user experience. CredibleMind uses a software called InVision to design mockups and test out workflows and prototypes. All user personas and workflows are represented with detailed emphasis on feature gaps including referral workflows. Key onboarding features include:

1. A primary call-to-action to start screening in English or Spanish
2. Option to view Need Help Now resources
3. Option to view Frequently Asked Questions
4. Option to Sign Up and Create an Account
5. Option to retrieve a prior result anonymously via an Access Code

The following key application and referral process features include:

1. Guidance to user taking Screener for self or on behalf of someone else
2. Branching and adaptive Screener questions including demographics collection
3. User results categorized by levels of concern per result scale segmentation
4. User referral guidance to a primary behavioral health agency and also to other local resources
5. Segmentation of referral guidance by age range, insurance type and other factors
6. Prioritization of referral locations by user detected location or specified city
7. Anonymous or signed in user option to share an Access Code to retrieve anonymized results
8. User option to create an account and save results to a user profile
9. Users with account created may have results emailed to them
10. All users may download results

Onboarding and application prototypes are being dynamically updated. There is a slide deck with screenshots that serves as a record of the user testing version (Appendix E as additional upload). To access the onboarding and application prototypes in responsive screen widths, follow these links:

Desktop: https://crediblemindfeedback602374.invisionapp.com/console/share/NFX4VZUQEWA
iPad: https://crediblemindfeedback602374.invisionapp.com/console/share/YSBJT6F9PQN
iPhone: https://crediblemindfeedback602374.invisionapp.com/console/share/PWTDUCQKXE4

Prototype of Ability for Provider to Access User Results

To ensure that providers do not need to be authenticated and credentialed, all provider functionality is offered within the main workflows. Please reference the links above under Onboarding Prototype. Key features include the following:

1. An At the Clinic mode uses appropriate prompts to users at the end of a screening
2. View Clinical Results options are offered from the home screen and from specific results
3. Provider can receive an Access Code from a user who has taken the screening and view anonymized results
4. Clinical Results include user item responses and validated scale information

5. Clinical Results PDF may be downloaded for upload into an EHR

Live Platform Configuration with Questions

The live working configuration is now available on the CredibleMind platform. It includes features marked "not a feature gap" in the Business Requirements (available upon request). It also includes the complete draft set of screening questions. Key functionality includes:

1. A primary call-to-action to start screening in English or Spanish
2. Option to view Need Help Now resources
3. Option to view Frequently Asked Questions
4. Option to Sign Up and Create an Account
5. Answer screener questions on behalf of self
6. Placeholder questions and results (screener does not represent final set of questions)

To access the live platform configurations, follow these links:

Test Site in Production Environment:	testmonterey.crediblemind.com
Test Site in Staging Environment:	cm-staging.netlify.app/?brand=testmonterey

11. Hosting and Access Options

CredibleMind offers hosting and access as a stand-alone site or embedded within an existing site. Stand-alone options and features are as follows:

- Option 1: Any available subdomain of crediblemind.com such as monterey.crediblemind.com
- Option 2: A purchased domain of your choice such as screenme.info
- Includes deep linking management
- Advantages - Easy to launch and link current county pages to it

Embedded options are as follows:

- Embed within your menu header on a page (Instructions in Separate Document provided)
- Takes a web developer an hour or two to set up and test
- Managed through CredibleMind platform self serve tools and service team
- Includes deep linking management using your domain
- Advantages - Easy to direct existing users and retain users on your site

Appendix H: Draft Screening Tool

CredibleMind

CredibleMind

Appendix B: July draft of screening questions

Outline of structure

When users enter the screening homepage, they will see two options to take the screener: one in English and one in Spanish. Clicking

START will take them to the English version of the screener and clicking TOMAR will take them to the Spanish version.

Then, users will be asked the following questions and scales in order:

Page number	Category/Condition	Number of questions	Scale
1	Introductory demographics	4	n/a
2	Depression and Anxiety screening	4	PHQ-4
	Anxiety branching	+5	Rest of GAD-7
	Depression branching	+7	Rest of PHQ-9
3	Postpartum Depression branching	+10	Edinburgh Postnatal Depression Scale
4	Trauma/PTSD screening	1	PC-PTSD-5
	Trauma/PTSD branching	+5	Rest of PC-PTSD-5
5	Bipolar affectivity frequency	8	WERCAP (Washington Early Recognition Center Affectivity and Psychosis Screen)
	Bipolar affectivity functionality	+1-3	WERCAP

	branching		
	Substance-induced affectivity symptoms item	+1	WERCAP
6	Psychosis frequency	8	WERCAP

	Psychosis functionality branching	+1-8	WERCAP
	Substance-induced psychosis symptoms item	+1	WERCAP
7	(NEW) Eating disorders	5	SCOFF (Sick, Control, One, Fat, Food)
8	Substance use screening (21 and older)	5	TAPS (Tobacco, Alcohol, Prescription medication, and other Substance use) Part I
9	Tobacco and alcohol use branching	+1-7	TAPS Part II
10	Cannabis, stimulants (cocaine, crack, meth), and heroin branching	+1-9	TAPS Part II
11	Opioid, sedative, stimulant (Adderall, Ritalin), and other illegal or recreational drug branching	+1-10	TAPS Part II
12	Substance use screening (Under 21)	5	CRAFFT (Car, Relax, Alone, Forget, Friends, Trouble) 2.1+N (Nicotine)
13	Substance use branching (Under 21)	+5	CRAFFT 2.1+N
14	Nicotine branching (Under 21)	+15	CRAFFT 2.1+N
15	Concluding demographics (Prior behavioral health experience and social determinants of health)	4	n/a
16	Concluding demographics (Zip code, race/ethnicity, preferred language, local programs/services, health insurance)	7	n/a

Total question count:

Category/Condition	**Minimum number of questions**	**Maximum number of questions**
Anxiety	2	7
Depression	2	9
Postpartum depression	0	10
Trauma/PTSD	1	6
Bipolar	8	11
Psychosis	8	16
Substance-induced bipolar or	0	2

psychosis		
Eating disorders	5	5

Substance use		
- 21 and older	5	31
- Under 21	5	20
Demographics	15	15
TOTAL for non-pregnant youth	**46**	**91**
TOTAL for non-pregnant adult	**46**	**102**

English and Spanish draft versions

Page 1 of screener

Welcome! The questions below will help guide the questions you see later on. This questionnaire is anonymous. Your individual results will not be shared unless you choose to share them yourself.
¡Bienvenido! Las siguientes preguntas ayudarán a guiar las preguntas que le mostramos más adelante. Este cuestionario es anónimo. Sus resultados individuales no se compartirán a menos que elija compartirlos usted mismo.[1]

Category/ Scale	**Audience/ Branching**	**Question**	**Question type**	**English responses**	**Spanish responses**
Intro Demographic	All	How old are you? ¿Cuántos años tiene Ud.?	Multiple choice	0|15 or younger 1|16-17 years old 2|18-20 years old 3|21-24 years old 4|25-34 years old 5|35-44 years old 6|45-54 years old 7|55-64 years old 8|65 or over	0|15 años o menos 1|16-17 años 2|18-20 años 3|21-24 años 4|25-34 años 5|35-44 años 6|45-54 años 7|55-64 años 8|65 años o más
Intro Demographic	All	What is your gender? ¿Cuál es su género?	Multiple choice	0|Female 1|Male 2|Trans Woman 3|Trans Man 4|Non-binary 5|Genderqueer/ non-conforming	0|Mujer 1|Hombre 2|Mujer trans 3|Hombre trans 4|No binarie 5|Genderqueer/ no conforme

				6|I prefer not to say	6|Prefiero no decir
Intro Demographic	All	Are you pregnant or have you recently been pregnant? ¿Está embarazada o ha estado embarazada recientemente?	Binary	1|Yes 0|No	1|Sí 0|No

[1] All Spanish translations that did not come from researcher-translated scales have undergone cultural review

Intro Demographic	All	Have you been diagnosed for any of the conditions below, whether currently or in the past? Please check all that apply. ¿Ha sido diagnosticado con alguna de las siguientes condiciones, ya sea actualmente o en el pasado? Por favor marque todos los que apliquen.	Checklist	0|Anxiety disorder 1|Depression 2|Bipolar disorder 3|Postpartum or perinatal depression 4|Eating disorder 5|Personality disorder 6|PTSD 7|Substance use disorder 8|Schizophrenia 9|I prefer not to say 10|None of the above Other mental health condition	0|Ansiedad 1|Depresión 2|Trastorno bipolar 3|Depresión posparto o después del parto 4|Trastorno alimentario 5|Trastorno de personalidad 6|TEPT 7|Trastorno por consumo de sustancias 8|Esquizofrenia 9|Prefiero no decir 10|Ninguna de las anteriores Otra condición de salud mental

Page 2 of screener

Over the last two weeks, how often have you been bothered by the following problems?
Durante las últimas 2 semanas, ¿qué tan seguido ha tenido molestias debido a los siguientes problemas?

Category / Scale	Audience/ Branching	Question	Question type	English responses	Spanish responses
PHQ-4	All	1. Feeling nervous, anxious or on edge Se ha sentido nervioso(a), ansioso(a) o con los nervios de punta	4x4 Matrix	0|Not at all 1|Several days 2|More than half the days 3|Nearly every day	0|Ningún día 1|Varios días 2|Más de la mitad de los días 3|Casi todos los días
		2. Not being able to stop or control worrying No ha sido capaz de parar o controlar su preocupación			
		3. Feeling down, depressed or hopeless Se ha sentido decaído(a), deprimido(a) o sin esperanzas			
		4. Little interest or pleasure in doing things Poco interés o placer en hacer cosas			

ANXIETY BRANCHING—A score of 3 or more on questions 1 and 2 of the PHQ-4 would lead to the following:

Over the last two weeks, how often have you been bothered by the following problems?
Durante las últimas 2 semanas, ¿qué tan seguido ha tenido molestias debido a los siguientes problemas?

Category / Scale	Audience/ Branching	Question	Question type	English responses	Spanish responses
GAD-7	PHQ-4	3. Worrying too much about different things Se ha preocupado demasiado por motivos	5x4 Matrix	0|Not at all 1|Several	0|Ningún día 1|Varios días
	Anxiety Screening ≥ 3	diferentes		days 2|More than half the days 3|Nearly every day	2|Más de la mitad de los días 3|Casi todos los días
		4. Trouble relaxing Ha tenido dificultad para relajarse			
		5. Being so restless that it is hard to sit still Se ha sentido tan inquieto(a) que no ha podido quedarse quieto(a)			
		6. Becoming easily annoyed or irritable Se ha molestado o irritado fácilmente			
		7. Feeling afraid, as if something awful might happen Ha tenido miedo de que algo terrible fuera a pasar			

DEPRESSION BRANCHING—A score of 3 or more on questions 3 and 4 of the PHQ-4 would lead to the following:

Over the last two weeks, how often have you been bothered by the following problems?
Durante las últimas 2 semanas, ¿qué tan seguido ha tenido molestias debido a los siguientes problemas?

Category / Scale	Audience/ Branching	Question	Question type	English responses	Spanish responses
		3. Trouble falling or staying asleep, or sleeping too much Ha tenido dificultad para quedarse o permanecer dormido(a), o ha dormido demasiado			
		4. Feeling tired or having little energy Se ha sentido cansado(a) o con poca energía			

PHQ-9	PHQ-4 Depression Screening ≥ 3	5. Poor appetite or overeating Sin apetito o ha comido en exceso	7x4 Matrix	0|Not at all 1|Several days 2|More than half the days 3|Nearly every day	0|Ningún día 1|Varios días 2|Más de la mitad de los días 3|Casi todos los días
		6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down Se ha sentido mal con usted mismo(a)—o que es un fracaso o que ha quedado mal con usted mismo(a) o con su familia			
		7. Trouble concentrating on things, such as reading the newspaper or watching television Ha tenido dificultad para concentrarse en ciertas actividades, tales como leer el periódico o ver la televisión			
		8. Moving or speaking so slowly that other people could have noticed? Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual ¿Se ha movido o hablado tan lento que otras personas podrían haberlo notado? o lo contrario—muy inquieto(a) o agitado(a) que ha estado moviéndose mucho más de lo normal			
		9. Thoughts that you would be better off dead or of hurting yourself in some way Pensamientos de que estaría mejor muerto(a) o de lastimarse de alguna manera			

POSTPARTUM DEPRESSION BRANCHING—Selecting 1 ("Yes") to *Are you pregnant or have you recently been pregnant?* would lead to the following set of questions:

Because you told us you are pregnant or have recently been pregnant, we would like to know how you are feeling. Please choose the answer that comes closest to how you have felt IN THE PAST 7 DAYS, not just how you feel today.
Como usted está embarazada o ha estado embarazada recientemente, nos gustaría saber como se siente actualmente. Por favor marque la respuesta que más se acerca a como se ha sentido durante LOS ÚLTIMOS 7 DÍAS y no sólo como se ha sentido hoy.

Category / Scale	Audience / Branching	Question	Question type	English responses	Spanish responses [7]

EPDS	"Yes" to pregnancy screener item	*5 I have felt scared or panicky for no very good reason He sentido miedo o pánico sin motivo alguno	4-point scale	3|Yes, quite a lot 2|Yes, sometimes 1|No, not much 0|No, not at all	3|Sí, bastante 2|Sí, a veces 1|No, no mucho 0|No, en absoluto
EPDS	"Yes" to pregnancy screener item	*6. Things have been getting on top of me Las cosas me oprimen o agobian	4-point scale	3|Yes, most of the time I haven't been able to cope at all 2|Yes, sometimes I haven't been coping as well as usual 1|No, most of the time I have coped quite well 0|No, I have been coping as well as ever	3|Sí, la mayor parte del tiempo no he podido sobrellevarlas 2|Sí, a veces no he podido sobrellevarlas de la manera 1|No, la mayoría de las veces he podido sobrellevarlas bastante bien 0|No, he podido sobrellevarlas tan bien como lo hecho siempre
EPDS	"Yes" to pregnancy screener item	*7. I have been so unhappy that I have had difficulty sleeping Me he sentido tan infeliz, que he tenido dificultad para dormir	4-point scale	3|Yes, most of the time 2|Yes, sometimes 1|Not very often 0|No, not at all	3|Sí, casi siempre 2|Sí, a veces 1|No muy a menudo 0|No, en absoluto
EPDS	"Yes" to pregnancy screener item	*8. I have felt sad or miserable Me he sentido triste y desgraciada	4-point scale	3|Yes, most of the time 2|Yes, quite often 1|Not very often 0|No, not at all	3|Sí, casi siempre 2|Sí, bastante a menudo 1|No muy a menudo 0|No, en absoluto
EPDS	"Yes" to pregnancy screener item	*9. I have been so unhappy that I have been crying Me he sentido tan infeliz que he estado llorando	4-point scale	3|Yes, most of the time 2|Yes, quite often 1|Only occasionally 0|No, never	3|Sí, casi siempre 2|Sí, bastante a menudo 1|Ocasionalmente 0|No, nunca
EPDS	"Yes" to pregnancy screener item	*10. The thought of harming myself has occurred to me He pensado en hacerme daño	4-point scale	3|Yes, quite often 2|Sometimes 1|Hardly ever 0|Never	3|Sí, bastante a menudo 2|A veces 1|Casi nunca

					0|No, nunca

*Items marked with an asterisk are reverse-scored

Page 4 of screener

Sometimes things happen to people that are unusually or especially frightening, horrible, or traumatic. For example: a serious accident or fire, a physical or sexual assault or abuse, an earthquake or flood, a war, seeing someone be killed or seriously injured, having a loved one die through homicide or suicide.

A veces, a las personas les suceden cosas inusualmente o especialmente aterradoras, horribles o traumáticas. Por ejemplo: un accidente o incendio grave, una agresión o abuso físico o sexual, un terremoto o una inundación, una guerra, ver a alguien morir o lesionarse gravemente, que un ser querido muera por homicidio o suicidio.

Category / Scale	Audience/ Branching	Question	Question Type	English responses	Spanish responses
PC-PTSD-5	All	1. Have you ever experienced this kind of event? ¿Alguna vez ha experimentado este tipo de evento?	Boolean	1|Yes 0|No	1|Sí 0|No

TRAUMA/PTSD BRANCHING—Selecting 1 ("Yes") to the above question: *Have you ever experienced this kind of event?* would lead to the following set of questions:

In the past month, have you...
Durante el último mes, ¿usted...

Category / Scale	Audience/ Branching	Question	Question Type	English responses	Spanish responses
PC-PTSD-5	"Yes" to PTSD screener item	2. Had nightmares about it or thought about it when you did not want to? ¿Ha tenido pesadillas perturbadoras o piensa sobre esa experiencia sin quererlo?	Boolean	1|Yes 0|No	1|Sí 0|No
		3. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it? ¿Ha tratado, sin logro, de no pensar en la experiencia, o ha tratado a toda costa (o a todo costo) de evitar situaciones que le recuerden esa experiencia?			
		4. Been constantly on guard, watchful, or easily startled? ¿Ha estado a la defensiva, vigilante de su entorno, o se sobresalta fácilmente desde que tuvo esa experiencia?			
		5. Felt numb or detached from others, activities, or your surroundings? ¿Ha tenido sensaciones de entumecimiento en los brazos o en las piernas; se ha sentido aislado o desprendido de otros (amigos, seres queridos), de su			

		entorno, o de actividades que disfrutaba antes?			
		6. Felt guilty or unable to stop blaming yourself or others for the event(s) or any problems the event(s) may have caused? ¿Ha sentido culpable o incapaz de dejar de culparse a sí mismo oa los demás por los eventos o cualquier problema que los eventos puedan haber causado?			

BIPOLAR FUNCTIONING BRANCHING—Selecting a response greater than 0 ("No") on questions 1a, 3a, or 6a will display an additional question below for each that assesses functioning.

All screener pages related to the WERCAP will display the following page intro: *The next set of questions may feel sensitive or strange to answer. We ask these questions to everyone who takes this screener in order to get the most complete picture of your mental health. Please be as honest as possible. As a reminder, your responses are private and anonymous unless you choose to share them.*

El siguiente conjunto de preguntas puede parecer delicado o extraño de responder. Hacemos estas preguntas a todos los que hacen esta evaluación para obtener una imagen más completa de su salud mental. Por favor, sea lo más honesto posible. Como recordatorio, sus respuestas son privadas y anónimas a menos que elija compartirlas.

Please indicate how frequently you experience each item over the past 3 months

Por favor indique con qué frecuencia ha experimentado cada elemento en los últimos 12 meses

Category / Scale	Audience/ Branching	Question	Question Type	English responses	Spanish responses
WERCAP	All	1a. I have had sadness or depression lasting 1 month or longer He tenido tristeza o depresión durante un mes o más	6-point scale	0|No 1|Once 2|Rarely (less than yearly) 3|Sometimes (more than yearly to monthly) 4|Often (more than monthly to weekly) 5|Almost always (more than weekly to daily)	0|No 1|Una vez 2|Raramente (menos de una vez al año) 3|Algunas veces (más de una vez al año a una vez al mes) 4|A menudo (más de una vez al mes a una vez a la semana) 5 |Casi siempre (más de semanalmente a diario)

WERCAP	Question 1a > 0	1b. How much did it affect your functioning at home, work, or school, or with other people? ¿Cuánto afectó su funcionamiento en el hogar, el trabajo, la escuela o con otras personas?	Dropdown	0|Not at all 1|A little 2|Moderately 3|Severely	0|Nada 1|Un poco 2|Moderadamente 3|Severamente
WERCAP	All	2. I have been sad or depressed AND slept 5 hours or more than I normally do He estado triste o deprimido y he dormido cinco horas o más de lo normal	6-point scale	0|No 1|Once 2|Rarely (less than yearly) 3|Sometimes (more than yearly to monthly) 4|Often (more than monthly to weekly)	0|No 1|Una vez 2 |Raramente (menos de una vez al año) 3|A veces (más de una vez al año a una vez al mes) 4|A menudo (más de una vez al mes a una semana) 5|Casi siempre (más de una

				5|Almost always (more than weekly to daily)	semana a una vez al día)
WERCAP	All	3a. I have become angry for most of the day because of little things Me he enfadado la mayor parte del día por cosas pequeñas	6-point scale	0|No 1|Onc e 2|Rarely (less than yearly) 3|Sometimes (more than yearly to monthly) 4|Often (more than monthly to weekly) 5|Almost always (more than weekly to daily)	0|No 1|Una vez 2|Raramente (menos de una vez al año) 3|A veces (más de una vez al año a una vez al mes) 4|A menudo (más de una vez al mes a una vez a la semana) 5|Casi siempre (más de semanalmente a diario)
WERCAP	Question 3a > 0	3b. Did it ever lead to any problems at home, work or school, or with other people ¿Alguna vez le generó algún problema en el hogar, el trabajo o la escuela o con otras personas?	Dropdown	0|Not at all 1|A little 2|Moderately 3|Severely	0|Nada 1|Un poco 2|Moderadamente 3|Severamente
WERCAP	All	4. I have had sudden shifts between sadness and happiness for no apparent reason He tenido cambios repentinos entre la tristeza y la felicidad sin razón aparente	6-point scale	0|No 1|Onc e 2|Rarely (less than yearly) 3|Sometimes (more than yearly to monthly) 4|Often (more than monthly to weekly) 5|Almost always (more than weekly to daily)	0|No 1|Una vez 2|Raramente (menos de una vez al año) 3|A veces (más de una vez al año a una vez al mes) 4|A menudo (más de una vez al mes a una vez a la semana) 5|Casi siempre (más que semanalmente a diario)

WERCAP	All	5. I have had extreme happiness or “highs” that others thought were excessive lasting 2 days or longer He tenido una felicidad extrema o “elevaciones” que otros pensaban que eran excesivas y que duraban dos días o más	6-point scale	0|No 1|Onc e 2|Rarely (less than yearly) 3|Sometimes (more than yearly to monthly) 4|Often (more than monthly to weekly) 5|AImost always (more than weekly to daily)	0|No 1|Una vez 2|Raramente (menos de una vez al año) 3|A veces (más de una vez al año a una vez al mes) 4|A menudo (más de una vez al mes a una semana) 5|Casi siempre (más de una vez a una semana a una vez al día)
WERCAP	All	6a. I have had so much energy that I felt little or no need to sleep He tenido tanta energía que sentí poca o ninguna	6-point scale	0|No 1|Onc e 2|Rarely (less than yearly) 3|Sometimes (more	0|No 1|Una vez 2|Raramente (menos de una vez al año) 3|Algunas veces (más de

		necesidad de dormir		than yearly to monthly) 4|Often (more than monthly to weekly) 5|Almost always (more than weekly to daily)	una vez al año a una vez al mes) 4|A menudo (más de una vez al mesa semanal) 5|Casi siempre (más de semanal a diario)
WERCAP	Question 6a > 0	6b. What was the longest time you slept this way? *¿Cuál fue el tiempo más largo que durmió de esta manera?*	Dropdown	0|1 day 1|2-3 days 2|4-7 days 3|Over 1 week	0|Un día 1|2-3 días 2|4-7 días 3|Más de una semana
WERCAP	All	7. Ideas and thoughts have come to me so fast that I could not express them all Las ideas y los pensamientos me han llegado tan rápido que no puedo expresarlos todos	6-point scale	0|No 1|Once 2|Rarely (less than yearly) 3|Sometimes (more than yearly to monthly) 4|Often (more than monthly to weekly) 5|Almost always (more than weekly to daily)	0 |No 1|Una vez 2|Raramente (menos de una vez al año) 3|A veces (más de una vez al año a una vez al mes) 4|A menudo (más de una vez al mes a una vez a la semana) 5|Casi siempre (más de una vez a la semana a una vez al día)
WERCAP	All	8. I have felt that I have great abilities or supernatural powers which no other person in the world has He sentido que tengo grandes habilidades o poderes sobrenaturales que ninguna otra persona en el mundo tiene	6-point scale	0|No 1|Once 2|Rarely (less than yearly) 3|Sometimes (more than yearly to monthly) 4|Often (more than monthly to weekly) 5|Almost always (more than weekly to daily)	0|No 1|Una vez 2|Raramente (menos de una vez al año) 3|Algunas veces (más de una vez al año) 4|A menudo (más de mensual a semanal) 5|Casi siempre (de más de semanal a diario)

SUBSTANCE-INDUCED BIPOLAR BRANCHING—If a user selects a response greater than 0 ("No") on any bipolar frequency item, that same item will display in a panel at the end of the eight bipolar

WERCAP item.

Users respond Yes or No to which item(s) they think may have been experienced due to substances.

Category/ Scale	Audience/ Branching	Question	Question Type	Coded responses
WERCAP	*Any bipolar frequency question > 0*	Do you think drugs or alcohol may have caused you to experience any of the below? ¿Cree que las drogas o el alcohol pueden haberle causado experimentar alguna de las siguientes?	Boolean	1|Yes/Sí 0|No

PSYCHOSIS FUNCTIONING BRANCHING—Selecting a response greater than 0 ("No") on all questions (9a-16a) will display an additional question below for each that assesses functioning.

Please indicate how frequently you experience each item over the past 3 months
Por favor indique con qué frecuencia ha experimentado cada elemento en los últimos 12 meses

Category / Scale	Audience/ Branching	Question	Question Type	English responses	Spanish responses
WERCAP	All	9a. I have been confused whether something I've experienced is real or imaginary Me ha confundido si algo que he experimentado es real o imaginario	6-point scale	0|No 1|Once 2|Rarely (less than yearly) 3|Sometimes (more than yearly to monthly) 4|Often (more than monthly to weekly) 5|Almost always (more than weekly to daily)	0|No 1|Una vez 2|Raramente (menos de una vez al año) 3|Algunas veces (más de una vez al año a una vez al mes) 4|A menudo (más de una vez al mesa semanal) 5|Casi siempre (más de semanal a diario)
WERCAP	Question 9a > 0	9b. How much did it affect your functioning at home, work or school, or with other people ¿Cuánto afectó su funcionamiento en el hogar, el trabajo o la escuela o con otras personas?	Dropdown	0|Not at all 1|A little 2|Moderately 3|Severely	0|Nada 1|Un poco 2|Moderadamente 3|Severamente

WERCAP	All	10a. I felt my mind was taken over by strange forces that were making me do things I did not choose to do Sentí que fuerzas extrañas se apoderaban de mi mente y me obligaban a hacer cosas que no elegí hacer	6-point scale	0|No 1|Onc e 2|Rarely (less than yearly) 3|Sometimes (more than yearly to monthly) 4|Often (more than monthly to weekly) 5|AImost always (more than weekly to daily)	0|No 1|Una vez 2|Raramente (menos de una vez al año) 3|Algunas veces (más de una vez al año a una vez al mes) 4|A menudo (más de una vez al mesa semanal) 5|Casi siempre (más de semanal a diario)
WERCAP	Question 10a > 0	10b. How much did it affect your functioning at home, work or school, or with other people ¿Cuánto afectó su funcionamiento en el hogar, el trabajo o la escuela o con otras personas?	Dropdown	0|Not at all 1|A little 2|Moderately 3|Severely	0|Nada 1|Un poco 2|Moderadamente 3|Severamente
WERCAP	All	11a. I felt that that some force was putting (or removing) thoughts into (or from) my head Sentí que alguna fuerza estaba poniendo (o quitando) pensamientos en (o de) mi cabeza	6-point scale	0|No 1|Onc e 2|Rarely (less than yearly) 3|Sometimes (more than yearly to monthly) 4|Often (more than monthly to weekly) 5|AImost always (more than weekly to daily)	0|No 1|Una vez 2|Raramente (menos de una vez al año) 3|Algunas veces (más de una vez al año a una vez al mes) 4|A menudo (más de una vez al mesa semanal) 5|Casi siempre (más de semanal a diario)

WERCAP	Question 11a > 0	11b. How much did it affect your functioning at home, work or school, or with other people? ¿Cuánto afectó su funcionamiento en el hogar, el trabajo o la escuela o con otras personas?	Dropdown	0|Not at all 1|A little 2|Moderately 3|Severely	0|Nada 1|Un poco 2|Moderadamente 3|Severamente
WERCAP	All	12a. I have thought that people might be able to read my mind or that I can read other people's minds He pensado que la gente podría ser capaz de leer mi mente o que yo puedo leer la mente de otras personas.	6-point scale	0|No 1|Once 2|Rarely (less than yearly) 3|Sometimes (more than yearly to monthly) 4|Often (more than monthly to weekly) 5|AImost always (more than weekly to daily)	0|No 1|Una vez 2|Raramente (menos de una vez al año) 3|Algunas veces (más de una vez al año a una vez al mes) 4|A menudo (más de una vez al mesa semanal) 5|Casi siempre (más de semanal a diario)
WERCAP	Question 12a > 0	12b. How much did it affect your functioning at home, work or school, or with other people? ¿Cuánto afectó su funcionamiento en el hogar, el trabajo o la escuela o con otras personas?	Dropdown	0|Not at all 1|A little 2|Moderately 3|Severely	0|Nada 1|Un poco 2|Moderadamente 3|Severamente
WERCAP	All	13a. I have thought that some force communicated directly with me by sending special signs that only I could understand He pensado que alguna fuerza	6-point scale	0|No 1|Once 2|Rarely (less than yearly) 3|Sometimes (more than yearly to monthly) 4|Often (more than	0|No 1|Una vez 2|Raramente (menos de una vez al año) 3|Algunas veces (más de una vez al año a una vez al mes)

		se comunicaba directamente conmigo enviándome señales especiales que solo yo podía entender		monthly to weekly) 5|Almost always (more than weekly to daily)	4|A menudo (más de una vez al mesa semanal) 5|Casi siempre (más de semanal a diario)
WERCAP	Question 13a > 0	13b. How much did it affect your functioning at home, work or school, or with other people ¿Cuánto afectó su funcionamiento en el hogar, el trabajo o la escuela o con otras personas?	Dropdown	0|Not at all 1|A little 2|Moderately 3|Severely	0|Nada 1|Un poco 2|Moderadamente 3|Severamente
WERCAP	All	14a. I have thought that someone is planning to harm me or is following me, when others did not think this was true He pensado que alguien está planeando hacerme daño o me está siguiendo, cuando otros no pensaban que esto era cierto	6-point scale	0|No 1|Once 2|Rarely (less than yearly) 3|Sometimes (more than yearly to monthly) 4|Often (more than monthly to weekly) 5|Almost always (more than weekly to daily)	0|No 1|Una vez 2|Raramente (menos de una vez al año) 3|Algunas veces (más de una vez al año a una vez al mes) 4|A menudo (más de una vez al mesa semanal) 5|Casi siempre (más de semanal a diario)
WERCAP	Question 14a > 0	14b. How much did it affect your functioning at home, work or school, or with other people ¿Cuánto afectó su funcionamiento en el hogar, el trabajo o la escuela o con otras personas?	Dropdown	0|Not at all 1|A little 2|Moderately 3|Severely	0|Nada 1|Un poco 2|Moderadamente 3|Severamente

WERCAP	All	15a. I have heard a voice or sound that others around me didn't seem to hear Escuché una voz o un sonido que otros a mi alrededor no parecían escuchar.	6-point scale	0|No 1|Onc e 2|Rarely (less than yearly) 3|Sometimes (more than yearly to monthly) 4|Often (more than monthly to weekly) 5|AImost always (more than weekly to daily)	0|No 1|Una vez 2|Raramente (menos de una vez al año) 3|Algunas veces (más de una vez al año a una vez al mes) 4|A menudo (más de una vez al mesa semanal) 5|Casi siempre (más de semanal a diario)
WERCAP	Question 15a > 0	15b. How much did it affect your functioning at home, work or school, or with other	Dropdo wn	0|Not at all 1|A little 2|Moderately 3|Severely	0|Nada 1|Un poco 2|Moderadamente 3|Severamente

		people? ¿Cuánto afectó su funcionamiento en el hogar, el trabajo o la escuela o con otras personas?			
WERCAP	All	16a. I have seen objects, people or animals that others around me didn't seem to see He visto objetos, personas o animales que otros a mi alrededor no parecían ver	6-point scale	0|No 1|Onc e 2|Rarely (less than yearly) 3|Sometimes (more than yearly to monthly) 4|Often (more than monthly to weekly) 5|AImost always (more than weekly to daily)	0|No 1|Una vez 2|Raramente (menos de una vez al año) 3|Algunas veces (más de una vez al año a una vez al mes) 4|A menudo (más de una vez al mesa semanal) 5|Casi siempre (más de semanal a diario)

WERCAP	Question 16a > 0	16b. How much did it affect your functioning at home, work or school, or with other people *¿Cuánto afectó su funcionamiento en el hogar, el trabajo o la escuela o con otras personas?*	Dropdown	0|Not at all 1|A little 2|Moderately 3|Severely	0|Nada 1|Un poco 2|Moderadamente 3|Severamente

SUBSTANCE-INDUCED PSYCHOSIS BRANCHING—If a user selects a response greater than 0 ("No") on any psychosis frequency item, that same item will display in a panel at the end of the eight psychosis WERCAP item.

Users respond Yes or No to which item(s) they think may have been experienced due to substances.

Category/ Scale	Audience/ Branching	Question	Question Type	Coded responses
WERCAP	*Any psychosis frequency question > 0*	Do you think drugs or alcohol may have caused you to experience any of the below? ¿Cree que las drogas o el alcohol pueden haberle causado experimentar alguna de las siguientes?	Boolean	1|Yes/Sí 0|No

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EATING DISORDERS

Category / Scale	Audience/ Branching	Question	Question Type	English responses	Spanish responses
SCOFF	All	1. Do you make yourself sick because you feel uncomfortably full? ¿Tiene la sensación de estar enfermo/a porque siente el estómago tan lleno que le resulta incómodo?	Boolean	1|Yes 0|No	1|Sí 0|No
SCOFF	All	2. Do you worry you have lost control over how much you eat? ¿Está preocupado/a porque siente que tiene que controlar cuánto come?			
SCOFF	All	3. Have you recently lost more than one stone (14 lbs or 6.35 kg) in a three-month period? ¿Ha perdido recientemente más de 14 lbs o 6 kgs en un período de tres meses?			
SCOFF	All	4. Do you believe yourself to be fat when others say you are too thin? ¿Cree que está gordo/a aunque otros digan que está demasiado delgado/a?			
SCOFF	All	5. Would you say food dominates your life? ¿Diría que la comida domina su vida?			

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21+ SUBSTANCE USE BRANCHING—Selecting 3 ("21-24 years old") or greater will display the following set of questions related to substance use:

All screener pages related to substance use will display the following page intro: *The following questions ask about using substances like alcohol, drugs, or medications. Please answer them honestly so we can show you the best referrals for your situation. Your answers will be kept private and confidential and will not be shared with Monterey County without your permission.*

Las siguientes preguntas se refieren al uso de sustancias como el alcohol, las drogas o medicaciones. Por favor responda honestamente para que podamos mostrarle las mejores referencias para su situación. Sus respuestas se mantendrán privadas y confidenciales y no se compartirán con el condado de Monterey sin su permiso.

In the PAST 12 MONTHS, how often have you…

En los últimos 12 meses, ¿con qué frecuencia…

Category / Scale	Audience/ Branching	Question	Question Type	English responses	Spanish responses
TAPS	Age 21 or older	1. Used tobacco or any other nicotine delivery product (i.e., e-cigarette, vaping or chewing tobacco)? Ha utilizado tabaco o otro producto de entrega de nicotina (por ejemplo, cigarrillos electrónicos, vapeo o tabaco para masticar)?	5-point scale	4|Daily or Almost Daily 3|Weekly 2|Monthly 1|Less Than Monthly 0|Never	4|Diario o casi diario 3|Semanal 2|Mensual 1|Menos de una vez al mes 0|Nunca
TAPS	Age 21 or older	2. Had 5 or more drinks (for males)/4 or more drinks (for females) containing alcohol in one day? *One standard drink is about 1 small glass of wine (5 oz), 1 beer (12 oz), or 1 single shot of liquor.* Ha tenido 5 o más bebidas (para hombres)/4 o más bebidas (para mujeres) que contengan alcohol en un día? *Una bebida estándar es aproximadamente 1 vaso pequeño de vino (5 onzas), 1 cerveza (12 oz), o 1 shot ("caballito" o "trago") de licor.*	5-point scale	4|Daily or Almost Daily 3|Weekly 2|Monthly 1|Less Than Monthly 0|Never	4|Diario o casi diario 3|Semanal 2|Mensual 1|Menos de una vez al mes 0|Nunca
TAPS	Age 21 or older	3. Used any drugs including marijuana, cocaine or crack, heroin, methamphetamine (crystal meth), hallucinogens, ecstasy/MDMA? Ha utilizado drogas, como marihuana, cocaína o crack, heroína, metanfetamina (hielo, crystal meth), alucinógenos, Éxtasis/MDMA?	5-point scale	4|Daily or Almost Daily 3|Weekly 2|Monthly 1|Less Than Monthly 0|Never	4|Diario o casi diario 3|Semanal 2|Mensual 1|Menos de una vez al mes 0|Nunca
		4. Used any prescription medications just for the feeling, more than prescribed or that were			

TAPS	Age 21 or older	not prescribed for you? *Prescription medications that may be used this way include: Opiate pain relievers (for example OxyContin, Vicodin, Percocet, Methadone); Medications for anxiety or sleeping (for example Xanax, Ativan, Klonopin); Medications for ADHD (for example Adderall or Ritalin)* Ha utilizado medicamentos recetados sólo para sentir el efecto, más de lo prescrito o que no fueron prescritos para usted? *Medicamentos recetados que pueden ser utilizados de esta manera incluyen: analgésicos opiáceos (por ejemplo, OxyContin, Vicodin, Percocet, Methadone); Medicamentos para la ansiedad o el sueño (por ejemplo, Xanax, Ativan, Klonopin); Medicamentos para el déficit de atención e hiperactividad (por ejemplo, Adderall o Ritalin)*	5-point scale	4|Daily or Almost Daily 3|Weekly 2|Monthly 1|Less Than Monthly 0|Never	4|Diario o casi diario 3|Semanal 2|Mensual 1|Menos de una vez al mes 0|Nunca

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21+ SUBSTANCE USE, ADDITIONAL BRANCHING—Selecting 0 ("Never") on question 1 (tobacco) or question 2 (alcohol) will display additional questions to assess use in the past 3 months. From there, there may be more branching questions assessing varying factors such as quantity, if there was a failed attempt to cut back or stop use, or if anyone has expressed concern.

Category / Scale	Audience/ Branching	Question	Question Type	English responses	Spanish responses

TAPS	Question 1 > 0	5a. In the PAST 3 MONTHS, did you smoke a cigarette containing tobacco or use any other nicotine delivery product (i.e., e-cigarette, vaping or chewing tobacco)? En los últimos 3 meses, ¿fumaste un cigarrillo que contenía tabaco o usaste algún otro producto de entrega de nicotina (por ejemplo, cigarrillo electrónico, vapeo o tabaco para mascar)?	Binary	1|Yes 0|No	1|Sí 0|No
Cigarettes branching intro statement: In the PAST 3 MONTHS... En los últimos 3 meses...					
TAPS	"Yes" to Question 5a	5b. Did you usually smoke more than 10 cigarettes each day, vape, use an e-cigarette or chew tobacco more than 10 times each day? ¿Fumó por lo general más de 10 cigarrillos cada día, vapeó, usó un cigarrillo electrónico o mascó tabaco más de 10 veces al día?	Binary	1|Yes 0|No	1|Sí 0|No
TAPS	"Yes" to Question 5a	5c. Did you usually smoke/use an e-cigarette, vape or chew tobacco within 30 minutes after waking? ¿Fumó/usó un cigarrillo electrónico, vapeó o masticó tabaco generalmente en los primeros 30 minutos después de despertarse?	Binary	1|Yes 0|No	1|Sí 0|No

Category / Scale	**Audience/ Branching**	**Question**	**Question Type**	**English responses**	**Spanish responses**
TAPS	Question 2 > 0	6a. In the PAST 3 MONTHS, did you have a drink containing alcohol? **One standard drink is about 1 small glass of wine (5 oz), 1 beer (12 oz), or 1 single shot of liquor.* En los últimos 3 meses, ¿tuvo una bebida que contenía alcohol? *Una bebida estándar es aproximadamente 1 vaso pequeño de vino (5 onzas), 1 cerveza (12 oz), o 1 shot ("caballito" o "trago") de licor.*	Binary	1|Yes 0|No	1|Sí 0|No
Alcohol branching intro statement: In the PAST 3 MONTHS... En los últimos 3 meses...					
TAPS	"Yes" to Question 4a	6b. Did you have 4 or more drinks (for females)/5 or more drinks (for males) containing alcohol in a day? ¿Tomó 4 o más bebidas que contenían alcohol	Binary	1|Yes 0|No	1|Sí 0|No

		en un día?		o	
TAPS	"Yes" to Question 4a	6c. Have you tried and failed to control, cut down or stop drinking? ¿Ha intentado y no ha podido controlar, reducir o detener su uso de alcohol?	Binary	1|Yes 0|No	1|Sí 0|No
TAPS	"Yes" to Question 4a	6d. Has anyone expressed concern about your drinking? ¿Alguien ha expresado preocupación por su consumo de alcohol?	Binary	1|Yes 0|No	1|Sí 0|No

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21+ SUBSTANCE USE, ADDITIONAL BRANCHING—Selecting 0 ("Never") on question 3 (drugs) will display additional questions to assess use of different types of drugs in the past 3 months. From there, there may be more branching questions assessing varying factors such as if there was a failed attempt to cut back or stop use or if anyone has expressed concern.

Category / Scale	Audience/ Branching	Question	Question Type	English responses	Spanish responses
TAPS	Question 3 > 0	7a. In the PAST 3 MONTHS, did you use marijuana (hash, weed)? En los últimos 3 meses, ¿uso marihuana (hash, weed)?	Binary	1|Yes 0|No	1|Sí 0|No
Marijuana branching intro statement: In the PAST 3 MONTHS... En los últimos 3 meses...					
TAPS	"Yes" to Question 5a	7b. Have you had a strong desire or urge to use marijuana at least once a week or more often? ¿Ha tenido un fuerte deseo o impulso de usar marihuana al menos una vez por semana o más a menudo?	Binary	1|Yes 0|No	1|Sí 0|No
TAPS	"Yes" to Question 5a	7c. Has anyone expressed concern about your use of marijuana? ¿Alguien ha expresado preocupación por su consumo de marihuana?	Binary	1|Yes 0|No	1|Sí 0|No

Category / Scale	Audience/ Branching	Question	Question Type	English responses	Spanish responses
TAPS	Question 3 > 0	8a. In the PAST 3 MONTHS, did you use cocaine, crack, or methamphetamine (crystal meth)? En los últimos 3 meses, ¿usó cocaína, crack, o	Binary	1|Yes 0|No	1|Sí 0|No

		metanfetamina (hielo, cristal meth)?			
Cocaine, crack, meth branching intro statement: In the PAST 3 MONTHS... En los últimos 3 meses...					
TAPS	"Yes" to Question 6a	8b. Did you use cocaine, crack, or methamphetamine (crystal meth) at least once a week or more often? ¿Ha utilizado cocaína, crack, o metanfetamina (hielo, cristal meth) por lo menos una vez por semana o más a menudo?	Binary	1|Yes 0|No	1|Sí 0|No
TAPS	"Yes" to Question 6a	8c. Has anyone expressed concern about your use of cocaine, crack, or methamphetamine (crystal meth)? ¿Alguien ha expresado preocupación por su consumo de cocaína, crack, o metanfetamina (hielo, cristal meth)?	Binary	1|Yes 0|No	1|Sí 0|No

Category / Scale	Audience/ Branching	Question	Question Type	English responses	Spanish responses
TAPS	Question 3 > 0	9a. In the PAST 3 MONTHS, did you use heroin? En los últimos 3 meses, ¿usó heroína?	Binary	1|Yes 0|No	1|Sí 0|No
Heroin branching intro statement: In the PAST 3 MONTHS... En los últimos 3 meses...					
TAPS	"Yes" to Question 7a	9b. In the PAST 3 MONTHS, have you tried and failed to control, cut down or stop using heroin? ¿Ha intentado y no ha podido controlar, reducir o dejar de usar heroína?	Binary	1|Yes 0|No	1|Sí 0|No
TAPS	"Yes" to Question 7a	9c. In the PAST 3 MONTHS, has anyone expressed concern about your use of heroin? ¿Alguien ha expresado preocupación por su consumo de heroína?	Binary	1|Yes 0|No	1|Sí 0|No

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21+ SUBSTANCE USE, ADDITIONAL BRANCHING—Selecting 0 ("Never") on question 4 (prescription meds) will display additional questions to assess use of different types of prescription meds in the past 3 months. From there, there may be more branching questions

assessing varying factors such as if there was a failed attempt to cut back or stop use or if anyone has expressed concern.

Category / Scale	Audience/ Branching	Question	Question Type	English responses	Spanish responses
TAPS	Question 4 > 0	10a. In the PAST 3 MONTHS, did you use a prescription opiate pain reliever (for example, Percocet, Vicodin) not as prescribed or that was not prescribed for you? En los últimos 3 meses, ¿ha utilizado un analgésico opiáceo prescrito (por ejemplo, Percocet, Vicodina), de una manera que no fue prescrita o un analgésico opiáceo	Binary	1|Yes 0|No	1|Sí 0|No

		que no le prescribieron?			
Opioid branching intro statement: In the PAST 3 MONTHS... En los últimos 3 meses...					
TAPS	"Yes" to Question 8a	10b. In the PAST 3 MONTHS, have you tried and failed to control, cut down or stop using an opiate pain reliever? ¿Ha intentado y no ha podido controlar, reducir o dejar de usar un analgésico opiáceo?	Binary	1|Yes 0|No	1|Sí 0|No
TAPS	"Yes" to Question 8a	10c. In the PAST 3 MONTHS, has anyone expressed concern about your use of an opiate pain reliever? ¿Alguien ha expresado preocupación por su consumo de un analgésico opiáceo?	Binary	1|Yes 0|No	1|Sí 0|No

Category / Scale	Audience/ Branching	Question	Question Type	English responses	Spanish responses
TAPS	Question 4 > 0	11a. In the PAST 3 MONTHS, did you use a medication for anxiety or sleep (for example, Xanax, Ativan, or Klonopin) not as prescribed or that was not prescribed for you? En los últimos 3 meses, ¿ha utilizado un medicamento para la ansiedad o el sueño (por ejemplo, Xanax, Ativan, o Klonopin) de una manera que no fue prescrita o un medicamento para la ansiedad o el sueño que no le prescribieron?	Binary	1|Yes 0|No	1|Sí 0|No
Anxiety or sleep medications branching intro statement: In the PAST 3 MONTHS... En los últimos 3 meses...					
TAPS	"Yes" to Question 9a	11b. In the PAST 3 MONTHS, have you had a strong desire or urge to use medications for anxiety or sleep at least once a week or more often? ¿Ha tenido un fuerte deseo o impulso de usar medicamentos para la ansiedad o el sueño por lo menos una vez por semana o más a menudo?	Binary	1|Yes 0|No	1|Sí 0|No
TAPS	"Yes" to Question 9a	11c. In the PAST 3 MONTHS, has anyone expressed concern about your use of medication for anxiety or sleep? ¿Alguien ha expresado preocupación por su consumo de medicamentos para la ansiedad o el sueño?	Binary	1|Yes 0|No	1|Sí 0|No

Category / Scale	Audience/ Branching	Question	Question Type	English responses	Spanish responses
TAPS	Question 4 > 0	12a. In the PAST 3 MONTHS, did you use a medication for ADHD (for example, Adderall, Ritalin) not as prescribed or that was not prescribed for you? En los últimos 3 meses, ¿ha utilizado un medicamento para el déficit de atención e hiperactividad (por ejemplo,	Binary	1|Yes 0|No	1|Sí 0|No
		Adderall, Ritalin) de una manera que no fue prescrita o un medicamento para el déficit de atención e hiperactividad que no le prescribieron?			
ADHD medications branching intro statement: In the PAST 3 MONTHS... En los últimos 3 meses...					
TAPS	"Yes" to Question 10a	12b. In the PAST 3 MONTHS, did you use a medication for ADHD (for example, Adderall, Ritalin) at least once a week or more often? ¿Ha utilizado un medicamento para el déficit de atención e hiperactividad (por ejemplo, Adderall, Ritalin) por lo menos una vez por semana o más a menudo?	Binary	1|Yes 0|No	1|Sí 0|No
TAPS	"Yes" to Question 10a	12c. In the PAST 3 MONTHS, has anyone expressed concern about your use of a medication for ADHD (for example, Adderall or Ritalin)? ¿Alguien ha expresado preocupación por su consumo de medicamentos para el "déficit de atención e hiperactividad" (por ejemplo, Adderall o Ritalin)?	Binary	1|Yes 0|No	1|Sí 0|No

NOTE: The last question of TAPS asks about use of any other illegal or recreational drug. It is not part of the first four TAPS question branching and all users 21+ will be asked 13a.

Category / Scale	Audience/ Branching	Question	Question Type	English responses	Spanish responses

TAPS	All	13a. In the PAST 3 MONTHS, did you use any other illegal or recreational drug (for example, ecstasy/molly, GHB, poppers, LSD, mushrooms, special K, bath salts, synthetic marijuana ('spice'),whip-its, etc.)? En los últimos 3 meses, ¿ha utilizado alguna otra droga ilegal o recreativa (por ejemplo, el éxtasis/Molly, GHB, Poppers, LSD, hongos, special K, sales de baño ('bath salts'), marihuana sintética ('Spice '), K2, whip-its, etc.)?	Binary	1|Yes 0|No	1|Sí 0|No
TAPS	"Yes" to Question 11a	13b. In the PAST 3 MONTHS, what were the other drug(s) you used? En los últimos 3 meses, ¿cuáles fueron las otras drogas que utilizó?	Short answer (text)		

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<21-YEARS-OLD SUBSTANCE USE BRANCHING—Selecting 2 ("18-20 years old") or less will display the following set of questions related to substance use:

During the PAST 12 MONTHS, on how many days did you…
Durante los ÚLTIMOS 12 MESES, cuántos días…

Category / Scale	Audience/ Branching	Question	Question Type
CRAFFT 2.1+N	Under 21	1. Drink more than a few sips of beer, wine, or any drink containing alcohol? Choose “0” if none. ¿Has bebido algo más que unos sorbos de cerveza, vino o alguna bebida con alcohol? Di “0” si ninguno.	Dropdown list from 0-9 and then "10 or more days" option
CRAFFT 2.1+N	Under 21	2. Use any marijuana (weed, oil, or hash, by smoking, vaping, or in food) or “synthetic marijuana” (like “K2,” “Spice”) or “vaping” THC oil? Choose “0” if none. ¿Has usado algún tipo de marihuana (cannabis, aceite, cera, para fumar, vaporizar, fumar dosis muy concentradas o “dabs” o en los alimentos) o “marihuana sintética” (como “K2”, “Spice”)? Di “0” si ninguno.	Dropdown list from 0-9 and then "10 or more days" option
CRAFFT 2.1+N	Under 21	3. Use anything else to get high (like other illegal drugs, prescription or over-the-counter medications, and things that you sniff, huff, or vape)? Choose “0” if none. ¿Has usado algo más para drogarte (como otras drogas ilegales, medicamentos recetados o de venta libre, y cosas para inhalar, esnifar, vaporizar o inyectarse)? Di “0” si la respuesta es ninguno.	Dropdown list from 0-9 and then "10 or more days" option
CRAFFT 2.1+N	Under 21	4. Use a vaping device* containing nicotine and/or flavors, or use any tobacco products**? Choose “0” if none. *Such as e-cigs, mods, pod devices like JUUL, disposable vapes like Puff Bar, vape pens, or e-hookahs. **Cigarettes, cigars, cigarillos, hookahs, chewing tobacco, snuff, snus, dissolvables, or nicotine pouches. ¿Has usado un dispositivo vaporizador* que contiene nicotina o sabores, o algún producto de tabaco**? Di “0” si la respuesta es ninguno. *Como cigarrillos electrónicos, “mods”, dispositivos “pod” como JUUL, vaporizadores descartables como Puff Bar, vaporizadores tipo bolígrafo o pipas de agua electrónicas. **Pitillos, cigarros, cigarrillos, pipas, tabaco de mascar, tabaco rapé, “snus” o solubles.	Dropdown list from 0-9 and then "10 or more days" option

CRAFFT 2.1+N	Under 21	5. Have you ever ridden in a CAR driven by someone (including yourself) who was “high” or had been using alcohol or drugs? ¿Alguna vez has viajado en un vehículo (CAR) conducido por alguien (incluido/a tú mismo/a) que estaba drogado o que había consumido alcohol o drogas?	Boolean

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<21-YEARS-OLD SUBSTANCE USE, ADDITIONAL BRANCHING—Typing in a number greater than 0 in the short answer fields for questions 1-3 will display additional questions related to alcohol and drug use. Typing in a number greater than 0 in the short answer fields for question 4 will display additional questions related to nicotine use.

Category / Scale	Audience/ Branching	Question	Question Type	English responses	Spanish responses
CRAFFT 2.1+N	>0 for Questions 1-3	6. Do you ever use alcohol or drugs to RELAX, feel better about yourself, or fit in? ¿Alguna vez consumes alcohol o drogas para relajarte, sentirte mejor contigo mismo/a o integrarte en un grupo?	Binary	0|No 1|Yes	0|No 1|Sí
CRAFFT 2.1+N	>0 for Questions 1-3	7. Do you ever use alcohol or drugs while you are by yourself, or ALONE? ¿Alguna vez consumes alcohol o drogas cuando estás solo/a o sin compañía?	Binary	0|No 1|Yes	0|No 1|Sí
CRAFFT 2.1+N	>0 for Questions 1-3	8. Do you ever FORGET things you did while using alcohol or drugs? ¿Alguna vez te olvidas de cosas que has hecho mientras consumías alcohol o drogas?	Binary	0|No 1|Yes	0|No 1|Sí
CRAFFT 2.1+N	>0 for Questions 1-3	9. Do your FAMILY or FRIENDS ever tell you that you should cut down on your drinking or drug use? ¿Tus familiares o amigos alguna vez te dicen que deberías disminuir el consumo de alcohol o drogas?	Binary	0|No 1|Yes	0|No 1|Sí
CRAFFT 2.1+N	>0 for Questions 1-3	10. Have you ever gotten into TROUBLE while you were using alcohol or drugs? ¿Alguna vez te has metido en problemas al consumir alcohol o drogas?	Binary	0|No 1|Yes	0|No 1|Sí

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The following questions ask about your use of any vaping devices containing nicotine and/or flavors, or use of any tobacco products.
Las siguientes preguntas son sobre el uso de dispositivos vaporizadores que contienen nicotina o sabores, o sobre el uso de productos de tabaco.

Category / Scale	Audience/ Branching	Question	Question Type	English responses	Spanish responses

CRAFFT 2.1+N	>0 for Question 4	11. Have you ever tried to quit using, but couldn't? ¿Alguna vez has intentado DEJAR de consumir, pero no pudiste?	Binary	0|No 1|Yes	0|No 1|Sí
CRAFFT 2.1+N	>0 for Question 4	2. Do you vape or use tobacco now because it is really hard to quit? ¿ACTUALMENTE usas vaporizador o tabaco porque te resulta muy difícil dejar de consumir?	Binary	0|No 1|Yes	0|No 1|Sí
CRAFFT 2.1+N	>0 for Question 4	3. Have you ever felt like you were addicted to vaping or tobacco? ¿Alguna vez has sentido que eres ADICTO/A al vaporizador o al tabaco?	Binary	0|No 1|Yes	0|No 1|Sí
CRAFFT 2.1+N	>0 for Question 4	4. Do you ever have strong cravings to vape or use tobacco? ¿Alguna vez sientes muchas GANAS de usar vaporizador o tabaco?	Binary	0|No 1|Yes	0|No 1|Sí
CRAFFT 2.1+N	>0 for Question 4	5. Have you ever felt like you really needed to vape or use tobacco? ¿Alguna vez sientes muchas GANAS de usar vaporizador o tabaco?	Binary	0|No 1|Yes	0|No 1|Sí
CRAFFT 2.1+N	>0 for Question 4	6. Is it hard to keep from vaping or using tobacco in places where you are not supposed to, like school? ¿Te resulta difícil evitar usar vaporizador o tabaco en LUGARES donde supuestamente no debes hacerlo, como la escuela?	Binary	0|No 1|Yes	0|No 1|Sí

When you haven't vaped or used tobacco in a while (or when you tried to stop using)...

Cuando NO HAS USADO vaporizador o tabaco durante un tiempo (o cuando has intentado dejar de usarlo)...

Category / Scale	Audience/ Branching	Question	Question Type	English responses	Spanish responses
		7a. Did you find it hard to concentrate because you couldn't vape or use tobacco? ¿Te resultó difícil CONCENTRARTE porque			

CRAFFT 2.1+N	>0 for Question 4	no podías usar vaporizador o tabaco?	4x2 Matrix	0|No 1|Yes	0|No 1|Sí
		7b. Did you feel more irritable because you couldn't vape or use tobacco? ¿Te sentiste más IRRITABLE porque no podías usar vaporizador o tabaco?			
		7c. Did you feel a strong need or urge to vape or use tobacco? ¿Sentiste NECESIDAD o ganas intensas de usar vaporizador o tabaco?			
		7d. Did you feel nervous, restless, or anxious because you couldn't vape or use tobacco? ¿Te sentiste NERVIOSO/A, inquieto/a o ansioso/a porque no podías usar vaporizador o tabaco?			

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The next questions ask about you and your experiences. Why is this important? We use the information you provide to refer you to the best resources and services for you.
Las siguientes preguntas se refieren a usted y sus experiencias. ¿Por qué es importante? Usamos la información que usted provee para referirle los mejores recursos y servicios.

Category/ Scale	Audience/ Branching	Question	Question Type	English responses	Spanish responses
Demographic	All	Are you currently receiving treatment or services for mental health or substance use? ¿Actualmente recibe tratamiento o servicios por salud mental o uso de sustancias?	Boolean	1|Yes 0|No	1|Sí 0|No
Demographic	All	Are you currently taking any medications for mental health or substance use? ¿Actualmente está tomando algún medicamento para la salud mental o el uso de sustancias?	Boolean	1|Yes 0|No	1|Sí 0|No
Demographic	All	Are you currently receiving services or have you ever received services from Monterey County Behavioral Health? ¿Recibe actualmente servicios o alguna vez ha recibido servicios de Salud conductual del condado de Monterey?	Boolean	1|Yes 0|No	1|Sí 0|No
				0|Housing (like homelessness, being able to pay rent, or being able to stay in your current home) 1|Physical health	0|Vivienda (falta de vivienda, pagar renta o poder permanecer en vivienda actual) 1|Salud física (enfermedad crónica,

Demographic	All	Are you currently having any significant challenges with the following items? Please check all that apply. ¿Actualmente tiene algún desafío significativo con los siguientes elementos? Por favor marque todos los que apliquen.	Checklist	(like chronic illness, pain, or disability) 2|Job/employment (like unemployment, finding a job, or keeping a job) 3|School (like missing school, being late to school, or maintaining good grades) 4|Food insecurity (like being able to pay for food or having access to healthy food options) 5|Transportation 6|Immigration 7|Family instability 8|None of the above	dolor o discapacidad) 2|Trabajo/empleo (desempleo, encontrar trabajo o mantener un trabajo) 3|Escuela (faltar a la escuela, llegar tarde a la escuela o mantener buenas calificaciones) 4|Seguridad alimentaria (poder pagar alimentos o tener acceso a opciones de alimentos saludables) 5|Transporte 6|Inmigración 7|Inestabilidad familiar 7|Ninguna de las anteriores

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The next questions ask about you and your experiences. Why is this important? We use the information you provide to refer you to the best resources and services for you.
Las siguientes preguntas se refieren a usted y sus experiencias. ¿Por qué es importante? Usamos la información que proporcionamos para referirse a los mejores recursos y servicios para usted.

Category/ Scale	**Audience/ Branching**	**Question**	**Question Type**	**English responses**	***Spanish responses***
Demographic	All	What is your zip code? ¿Cuál es su código postal?	Short answer (numeric)		

Demographic	All	Are you of Hispanic, Latino, or of Spanish origin? ¿Es usted de origen hispano, latino o español?	Binary	1|Yes 0|No	1|Sí 0|No
Demographic	All	What race do you identify with? Please check all that apply. ¿Con qué raza se identifica? Por favor marque todos los que apliquen.	Checklist	0|Indigenous, American Indian, or Alaska Native 1|Asian 2|Black 3|Native Hawaiian or Other Pacific Islander 4|White 5|Other race	0|Indígena, Indio/a Americano/a o Nativo/a de Alaska 1|Asiático/a 2|Negro/a 3|Hawaiano/a Nativo/a o de otras Islas del Pacífico 4|Blanco 5|Otra raza
Demographic	All	What is your language of preference? ¿Cuál es su idioma de preferencia?	Multiple choice	0|English 1|Spanish 2|Indigenous languages (e.g. Mixteco, Triqui, Chatino) 3|Other language	0|Inglés 1|Español 2|Lenguas indígenas (por ejemplo: Mixteco, Triqui, Chatino) 3|Otro idioma o lengua
Demographic	All	Are you involved with any of the following? Please check all that apply. ¿Está involucrado con alguno de los siguientes? Por favor marque todos los que apliquen.	Checklist	0|Foster care or child welfare services 1|The justice system 2|CalWORKS 3|Cal Fresh 4|Other open case with the Department of Social Services 5|None of the above	0|Servicios de orfanato o de bienestar infantil 1|El sistema de justicia 2|CalWORKS 3|Cal Fresh 4|Otro caso abierto con el Departamento de Servicios Sociales 5|Ninguna de las anteriores

Demographic	All	What health insurance do you have? Please check all that apply. ¿Qué seguro de salud tiene? Por favor marque todos los que apliquen.	Checklist	0|Medi-Cal or Medicaid 1|Medicare 2|Private insurance (either from your job, through Covered California, or as a dependent on someone else's insurance) 3|No insurance Other insurance	0|Medi-Cal o Medicaid 1|Medicare 2|Seguro privado (ya sea de su trabajo, a través de Covered California o como dependiente del seguro de otra persona) 3|Sin seguro Otro seguro de salud
Demographic	All	How did you find out about this mental health questionnaire? Please check all that apply. *MCBH = Monterey County Behavioral Health* ¿Cómo se enteró de este cuestionario de salud mental? Por favor marque todos los que apliquen. *MCBH = Monterey County Behavioral Health*	Checklist	0|A provider, counselor, or therapist who works for MCBH 1|A mental health or substance use provider who does not work for MCBH 2|Social media 3|The Monterey County website 4|An advertisement, flyer, or billboard in the community 5|Friend or family member 6|My primary care physician or other doctor or nurse 7|School or work Other (describe)	0|Un médico/a, consejero/a o terapeuta que trabaja para MCBH 1|Un médico/a de salud mental o consumo de sustancias, que no trabaja para MCBH 2|Redes sociales 3|El sitio del Condado de Monterey 4|Un anuncio, volante o valla publicitaria en la comunidad 5|Amigo/a o familiar 6|Mi médico de atención primaria u otro médico o enfermera 7|Escuela o trabajo Otro

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De la detección al acceso oportuno

Informe final resumido de la evaluación anual

Enero de 2023

EVALCORP
Measuring What Matters℠

MONTEREY COUNTY
BEHAVIORAL HEALTH
Avanzando Juntos Forward Together

TABLA DE CONTENIDOS

Introducción

Monterey County Behavioral Health (MCBH) creó el programa “Screening to Timely Access” (De la detección al acceso oportuno) como parte de la “Tech Suite Collaborative” de varios condados, que recibió el nombre de “Help@Hand”. En el marco de esta colaboración, los condados propusieron y/o probaron tecnologías de salud mental. El Condado de Monterey, específicamente, creó una herramienta de autoevaluación y referencias llamada “WellScreen Monterey” (WellScreen). El proyecto se diseñó como una aplicación web integral de evaluación de la salud mental que puede detectar un amplio espectro de trastornos mentales y referir a las personas al nivel adecuado de atención dentro del sistema de MCBH. El objetivo de esta aplicación es continuar expandiendo el alcance de MCBH en la comunidad y ayudar a reducir el tiempo dedicado a las evaluaciones, ya que MCBH puede utilizar la herramienta de detección para clasificar a las personas en el nivel correcto de necesidad de atención. Esta herramienta de detección ayudará a informar a las personas sobre su nivel de necesidad y los recursos de que disponen. El proyecto, de cinco años de duración, comenzó en 2019 y finaliza en diciembre de 2023. El proyecto se financia con fondos de la Ley de Innovación de Servicios de Salud Mental.

MCBH contrató a EVALCORP para evaluar el impacto del proyecto WellScreen. La participación de EVALCORP en la evaluación comenzó en 2022. Este informe incluye información relacionada con el programa, así como una reseña de los métodos de evaluación y los resultados para el AF 21/22.

Proyecto De la detección al acceso oportuno

El principal problema que aborda este proyecto de innovación es que la demanda de servicios de salud mental supera la capacidad del sistema de salud mental para examinar y referir adecuadamente a estas personas al tratamiento. MCBH organiza sus “sistemas de atención” en tres áreas: (1) servicios para adultos, (2) servicios para niños y (3) servicios ACCESS. El sistema de atención ACCESS incluye servicios de intervención temprana, incluida la evaluación y referencia, para las personas que manifiestan síntomas de enfermedad mental. Los servicios de acceso al tratamiento de MCBH representan un nivel de atención para las personas con trastornos moderados y una puerta de acceso a los servicios intensivos. La demanda de servicios en los programas ACCESS ha experimentado un aumento significativo en los últimos años, con un incremento de más del 100 % en el número de clientes atendidos en el trienio AF 2015-2017, pasando de 2,521 a 5,087. Mientras tanto, el nivel de personal capaz de responder a estas necesidades de la comunidad no ha cambiado. Los procesos de planificación comunitaria de MCBH también han revelado una falta de conocimiento en la comunidad sobre los servicios de salud mental disponibles y la presencia de un estigma persistente asociado con los problemas de salud mental, particularmente entre las comunidades latinas. Por lo tanto, MCBH cree que la demanda de estos servicios ACCESS seguirá aumentando con el tiempo.

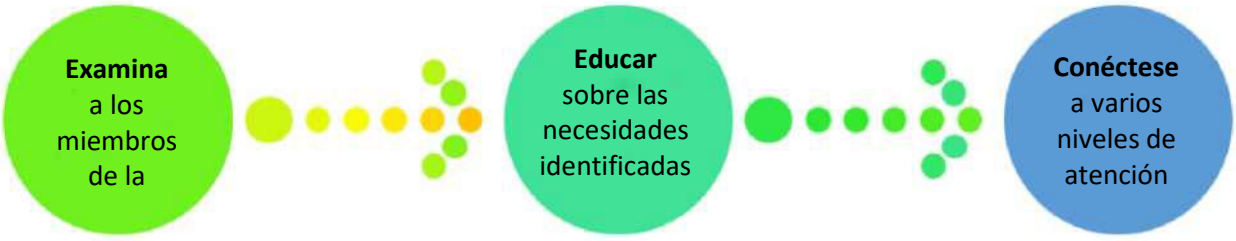
El objetivo de este proyecto es desarrollar una nueva herramienta de detección basada en Internet que ayude a las personas a conocer sus posibles necesidades y las ponga rápidamente en contacto con el tratamiento adecuado. La herramienta se construyó independientemente de cualquier aplicación de MCBH o Technology Suite existente, y solo se consideró la posible vinculación con las aplicaciones Technology Suite en una fecha futura cuando sea factible y aplicable. La herramienta está diseñada para su uso por parte de personas mayores de 16 años y está disponible en inglés y español.

La herramienta se desarrolló con los criterios básicos de:

- Tener capacidad para detectar una amplia gama de trastornos, desde los de bajo riesgo con nivel de necesidad leve hasta los graves con nivel de necesidad urgente.
- De fácil acceso para que los proveedores de servicios comunitarios ayuden a las personas a comprender la necesidad de tratamiento.
- Mantener las normas de confidencialidad.
- Interfaz con el sistema de registro de salud electrónico Avatar de MCBH para proporcionar transiciones más fluidas hacia la atención.
- Trabajar con fluidez en español. La herramienta de detección incorporará perspectivas de la comunidad latina e incluirá matices culturales que reflejen cómo los latinos entienden y se relacionan con la salud mental.
- Basarse en las actuales herramientas de detección basadas en pruebas con validez demostrada y utilizar la teoría de respuesta al elemento para minimizar el número de preguntas involucradas en la evaluación.

Mediante el uso de la herramienta de detección basada en la web, el tipo y la gravedad de los problemas de salud mental serán identificados junto con el correspondiente programa de tratamiento de MCBH que mejor se adapte a sus necesidades. El usuario tendrá la opción de ver la información de contacto de referencia adecuada o transmitir la información de salud a MCBH para que el personal de MCBH la revise y le devuelva la llamada (Figura 1).

Figura 1. Reseña del proyecto



El principal objetivo de aprendizaje de este proyecto es determinar si el proyecto en sí aumenta el acceso a los servicios de salud mental en el Condado de Monterey. Para evaluar la relación entre el uso de esta aplicación y una mayor accesibilidad a los servicios, así como su valor para los consumidores/usuarios en general, se evaluaron los siguientes objetivos de aprendizaje:

- Determinar si esta herramienta de detección mide con precisión el tipo y la gravedad de la enfermedad mental.
- Determinar si esta aplicación proporciona conexiones de referencias significativas y precisas al servicio/recurso adecuado de la forma más eficiente posible.
- Evaluar si esta herramienta de detección basada en la web reduce las horas y el costo asociados a las evaluaciones en persona.
- Evaluar el impacto de la implementación de esta aplicación en el volumen total de clientes que acceden a los servicios ACCESS, incluido su efecto en la demografía de los clientes atendidos.
- Evaluar si las personas (personal, proveedores comunitarios, iguales, etc.) que utilizan esta aplicación para ayudar a una persona necesitada la consideran útil para poner a dicha persona en contacto con los recursos. Muchos organismos locales manifestaron su interés en probarla, incluidas las fuerzas del orden, que esperan utilizar esta herramienta para poner en contacto a los miembros de la comunidad con la asistencia de salud.

Métodos de evaluación

La etapa del proyecto durante el AF 21/22 fue el desarrollo de la herramienta de detección. Por lo tanto, este informe se centra en describir el proceso de desarrollo y evaluación utilizado para crear y probar la herramienta y resumir los datos. La fuente de datos fueron los documentos existentes desarrollados por MCBH y CredibleMind, el proveedor que creó la herramienta de detección.

La evaluación de WellScreen está diseñada para responder a las preguntas de aprendizaje y evaluación planteadas para el proyecto e incluye estrategias de recolección de datos cualitativas y cuantitativas. Además, se utilizarán metodologías cuantitativas y cualitativas para evaluar el impacto y el valor de la aplicación propuesta en este proyecto. Los datos de la aplicación sobre datos demográficos de los usuarios, datos de evaluación y datos de remisión se evaluarán y utilizarán para diversas estrategias de evaluación. Para medir si la aplicación detectó con precisión el tipo y la gravedad de la enfermedad mental, se realizarán encuestas de seguimiento y/o referencias cruzadas con los datos del servicio Avatar. Se utilizará una metodología similar para evaluar la eficacia de las funciones de remisión/vinculación de la aplicación. Para medir cualquier reducción de las horas de personal dedicadas a la evaluación de los clientes, se analizarán los datos de Avatar correspondientes a las horas de personal dedicadas a estas actividades de servicio. También se hará referencia a los datos de Avatar para evaluar el impacto agregado que el uso de esta aplicación puede tener en el aumento del número total de clientes atendidos. Por último, se recopilará información cualitativa para evaluar la experiencia de los usuarios. Esta información se solicitará al espectro de usuarios. Entre los posibles usuarios se encuentran el personal clínico y policial, los proveedores comunitarios, los consumidores, los promotores/trabajadores de salud comunitarios y el personal de la línea de Access.

Limitaciones

Como ocurre con cualquier evaluación, la evaluación WellScreen se enfrentó a limitaciones impuestas por las circunstancias. El equipo de EVALCORP no participó en la investigación realizada para crear la herramienta de detección. Además, las conclusiones se basan en documentos no elaborados por EVALCORP.

Descubrimientos

El desarrollo de la herramienta de detección comenzó cuando MCBH creó una solicitud de propuesta para identificar a un proveedor para desarrollar la herramienta (Anexo A). Las propuestas debían presentarse en febrero de 2021. En la solicitud de propuestas, las condiciones exigidas para identificar (como mínimo) eran:

- Depresión
- Trastorno bipolar
- Esquizofrenia
- Psicosis
- Trastorno de estrés postraumático (PTSD)
- Trastornos de ansiedad
- Trastornos por el abuso de sustancias

El proveedor seleccionado fue CredibleMind. El alcance de su trabajo se completó en agosto de 2021 (Anexo B). En octubre de 2021, CredibleMind completó un plan de investigación (Anexo C), que proporcionó un esquema de las tareas y actividades que CredibleMind llevaría a cabo para cumplir con los objetivos de investigación descritos en la declaración de trabajo.

En marzo de 2022, CredibleMind presentó su informe de investigación que incluía los resultados de la exploración del entorno, la revisión de la literatura, la evaluación de las necesidades y el mapeo de los sistemas de comportamiento (Anexo D). En la encuesta de evaluación de las necesidades (n = 32) se preguntó sobre otras afecciones, además de las siete requeridas, para incluirlas en la herramienta de detección. El 81 % de los encuestados (n = 26) sugirió que la ideación suicida era extremadamente importante para esta herramienta de encuesta, seguida de la depresión posparto (44 %, n = 14). La mitad de los participantes respondieron que los trastornos alimentarios (n = 16) eran muy importantes, seguidos de los trastornos del espectro autista (47 %, n = 15). La encuesta también incluía una lista de factores que influyen en la salud conductual, ya que estos elementos también se tuvieron en cuenta para la herramienta de detección. Los elementos seleccionados con más frecuencia fueron el historial de traumas (100 %, n = 32), seguido de la inseguridad alimentaria y la salud física (84 %, n = 27). El Anexo E contiene todos los resultados de la encuesta.

Tras la investigación, se elaboró un documento de diseño de funciones (Anexo F). El objetivo del documento era desarrollar personajes y recorridos de usuario para la aplicación de

detección. Estos elementos reflejaban la necesidad de un diseño receptivo que se adaptara fácilmente a usuarios anónimos, de modo que la aplicación pudiera ser utilizada por usuarios poco frecuentes sin necesidad de capacitación. Los resultados confirmatorios fueron:

- Los usuarios apreciaron el atractivo visual de la página de inicio inicial.
- Los usuarios apreciaron la opción de iniciar el proceso de detección en español (algunos usuarios eran bilingües y los no hispanohablantes también comentaron el valor de esta opción).
- Los usuarios confirmaron que, en general, están dispuestos a responder a las preguntas que se plantearon como representativas de toda la herramienta de detección.
- Los usuarios entendieron el resumen de sus resultados mostrado por niveles de preocupación. Algunos mostraron interés por saber más sobre las distintas afecciones.
- Los usuarios entendieron conceptualmente que, además de ver los resultados, se les podía derivar a los servicios, y apreciaron el concepto general de ser guiados hasta los servicios.

Las principales conclusiones sobre los problemas y las correspondientes medidas paliativas fueron las siguientes:

1. Página de inicio. La posibilidad de introducir un código de acceso confundió a un usuario. “¿Necesito un código de acceso para acceder a la herramienta de detección?”
    a. Mitigación. La versión desarrollada incluye una sección de código de acceso con modificaciones de texto para volver a probarlo.
2. Ejemplo de pregunta Formato Likert. Las preguntas en escala Likert que aparecen en distintos órdenes resultan más confusas para algunos usuarios. Un usuario comentó que el orden variaba, y otro que el diseño no era tan amigable como los botones de opción. Si bien las escalas validadas ofrecen flexibilidad, se prefiere la coherencia. Una de las partes interesadas también mencionó que las escalas Likert pueden no ser adecuadas para varios grupos de usuarios.
    a. Mitigación. Investigación continua y pruebas adicionales para revelar el mejor diseño en lo sucesivo.
3. Contexto de las preguntas de muestra. Los usuarios comentaron que deseaban saber por qué se les hacían determinadas preguntas demográficas.
    a. Mitigación. El diseño final incluía un plan para mejorar el contexto y descripciones para volver a realizar pruebas.
4. Llamadas de referencia a la acción. Los usuarios se mostraron confusos por la opción del código QR para acceder a los resultados, y volvieron a preguntar qué debían compartir en una llamada o traer consigo al ingresar personalmente.
    a. Mitigación. Un nuevo diseño sin código QR y con un mejor texto de instrucciones puede centrar a los usuarios en sus siguientes pasos y puede volver a probarse.
5. Opciones de resultados. Los usuarios preferían recibir los resultados por correo electrónico. Se sugirió que la página de resultados fuera el momento principal para solicitar la inscripción, más bien antes de ver los resultados.
    a. Mitigación. El orden de los botones para enviar información se ha modificado en función de estos comentarios.
6. Detalle de los resultados. Los usuarios expresaron su interés por saber más sobre cada

afección de salud y sus puntuaciones. Las secciones de resultados pueden incluir recursos de cuidado personal y, en función del interés, pueden presentarse mejor sin un acordeón colapsado.
    a. Mitigación. Estas opciones son configuraciones y pueden volver a probarse.
7. Horas y ubicaciones. A los usuarios les gusta esta función y han solicitado que la ubicación se detecte de forma opcional en lugar de tener que introducirla. Los usuarios quieren enlaces a Google Maps y tener acceso a un número de teléfono.
    a. Mitigación. Los planes de desarrollo incluían la detección de la ubicación del usuario y la investigación sobre la vinculación con Google Maps.

A continuación, CredibleMind creó los documentos técnicos (Anexo G) con el fin de documentar el diseño técnico de la solución para la herramienta de detección en cuanto a referencias. Se incluye información sobre temas como el flujo de trabajo, el diseño de datos, la arquitectura del sistema y un diccionario de datos.

Todo este trabajo realizado en el AF 21/22 culminó en un borrador de herramienta de detección (Anexo H), que se desarrolló en julio de 2022, parte del AF 22/23. El proyecto se incluye en este informe por ser el vértice de todo el trabajo del año en el AF 21/22.

El borrador de la herramienta de detección toma aproximadamente 10 minutos para completarse y está escrita en inglés y español. Las afecciones y el número de preguntas se presentan en la Tabla 1.

Tabla 1. Afecciones y número de preguntas

Categoría/Afección	Número mínimo de preguntas	Número máximo de preguntas
Ansiedad	2	7
Depresión	2	9
Depresión posparto	0	10
Trauma/TEPT	1	6
Trastorno bipolar	8	11
Psicosis	8	16
Bipolaridad o psicosis inducida por sustancias	0	2
Trastornos de la alimentación	5	5
Consumo de sustancias		
- 21 años y mayores	5	31
- Menores de 21 años	5	20
Aspectos demográficos	15	15
TOTAL para jóvenes no embarazadas	46	91
TOTAL para adultas no embarazadas	46	102

Las preguntas del cuestionario tienen un formato ramificado para que los usuarios no reciban preguntas irrelevantes. Las opciones de respuesta son de opción múltiple para agilizar el tiempo de cumplimentación y el análisis de los datos.

Discusión

Se espera que este proyecto ayude a los residentes del Condado de Monterey y a quienes prestan servicios a los miembros de la comunidad poniendo a su disposición una herramienta de detección para la evaluación de la salud mental 24 horas al día, siete días a la semana. El aumento de la necesidad de servicios ha creado dificultades para el acceso a los servicios que esta herramienta está diseñada para abordar. La herramienta también proporcionará información sobre enfermedades mentales y recursos de forma discreta para ayudar a reducir el impacto de la estigmatización. Por último, la herramienta referirá a los usuarios al nivel y lugar adecuados para recibir atención. MCBH también puede utilizar los datos recopilados para ayudar al condado a identificar tendencias en las condiciones de salud mental de manera oportuna. La información oportuna puede utilizarse para reorientar los flujos de financiamiento y los servicios y así minimizar el retraso en la respuesta a las necesidades cambiantes de la comunidad.

El desarrollo del proyecto de herramienta de detección ha sido reflexivo, exhaustivo y basado en pruebas. MCBH y el vendedor condujeron una cantidad extensa de investigación sobre las herramientas de detección, las necesidades de la comunidad, y los servicios en la comunidad. Esta información se incluyó en el diseño y el contenido de la herramienta de detección. Se probó la herramienta y se introdujeron los cambios pertinentes.

Resumen

El proyecto WellScreen es innovador y se espera que aborde problemas importantes, como la mayor necesidad de servicios y la capacidad limitada de los proveedores. La herramienta también ayudará a superar las barreras a la atención, como el estigma y la falta de conocimiento sobre los recursos del condado. Por último, WellScreen puede proporcionar datos en tiempo real al condado sobre las tendencias en la comunidad. En el AF 21/22, MCBH y su proveedor elegido se involucraron en un proceso sistemático y basado en la investigación para desarrollar el borrador de la herramienta de detección.

Appendix A: Request for Proposal to Develop Screening Tool

Request for Proposal Help@Hand Screening Tool Project

Applications due by 5:00pm on Thursday, February 18, 2021

MONTEREY COUNTY BEHAVIORAL HEALTH

Avanzando Juntos Forward Together

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH

hope. recovery. wellbeing.

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Project Background

The California Mental Health Services Authority (CalMHSA) is an independent administrative and fiscal government agency focused on the efficient delivery of California mental health projects. CalMHSA was established by California counties in June 2009, as a Joint Powers Authority (JPA). CalMHSA's member counties work together to develop, fund, and implement mental health services, projects, and educational programs at State, regional, and local levels. CalMHSA is headed by a separate Board of Directors composed of representatives of Member Counties and an Executive Committee comprised of officers and Statewide Regional Representatives. CalMHSA operates within the statutes governing JPA entities and complies with the Brown Act open meeting requirements.

CalMHSA, with the support of participating counties and cities has implemented a project called Help@Hand, which aims to build a complementary support system that offers a bridge to care, helps identify early signs of mental health changes, offers timely support, removes barriers, and seeks to include new avenues of care for communities not connected to conventional county services. Monterey County Behavioral Health (MCBH) and Los Angeles County Department of Mental Health (LACDMH) are two of the participating members of the JPA. CalMHSA, MCBH and LACDMH are working collaboratively to solicit responses to meet a need initially for Monterey County and Los Angeles County.

This Request for Proposal is intended to solicit interested parties with the ability and capacity to perform the services requested, with the intent to award a contract to the selected entity. However, there is no guarantee of a contract, as we are facing unprecedented times which could dictate otherwise for CalMHSA's participating members.

Primary Problem

The primary problem being addressed by this project is the demand for mental health services outpacing the capacity of the mental health services system to appropriately screen and refer these individuals to treatment. MCBH, who is the originator of this project, organizes its "Systems of Care" in three areas: Adult services, Children's services and ACCESS services. Their ACCESS System of Care includes gateway early intervention services, including assessment and referrals, for individuals expressing symptoms of mental illness. The demand for services in ACCESS programs has seen a significant increase in recent years, with the number of clients served over the three-year period from FY2015-17 increasing by more than 100%, from 2,521 to 5,087. Meanwhile, the level of staff capable of responding to these community needs has remained relatively unchanged. The MCBH community planning processes have also revealed both a lack of knowledge in the community about available mental health services and a persistent stigma associated with mental health issues, particularly among Latino communities. MCBH believes demand for ACCESS services will continue to increase over time. Additional counties, including Los Angeles County, are experiencing similar challenges.

Several mobile applications that promote mental health and wellness have entered the market space in recent years. However, a thorough scan of available products has only found two varieties of application functionality. The first is to provide guided meditations. The second is to provide the user an ability to log and rate their emotional state. No applications were discovered that have the functionality to screen for a broad spectrum of mental health disorders ranging from depression to schizophrenia, nor were any capable of providing MCBH or LACDMH referral resources. To better meet the increased demand for services, MCBH and LACDMH have proposed the development of a comprehensive web-based mental health assessment application that can screen for a broad spectrum of mental health disorders and refer individuals to the appropriate level of care within the local mental health system.

User Scenarios

The following user scenarios highlight the general user profile (including type of user and technical competency), the need or purpose of that user, and their desired result. These user scenarios are intended to highlight the end user characteristics and desires to be positively influenced by the target solution.

User Profile	Need	Desired Result
 Description: Family Member/Friend of an Individual that Experiences a Mental Health Disorder Technical Competency: Medium (Difficulty in navigating new applications, but has good smartphone, tablet, and laptop navigation capabilities).	A family member/friend of an individual experiencing symptoms of a mental health disorder can pull up this application on their phone or computer and guide their loved one through the screening tool.	The individual (and their family member / friend) will be educated on the symptoms they are experiencing, associated risks and treatment options, and local resource information.

 Description: Individual entering Mental Health Clinic or taking assessment without support from others. Technical Competency: Low (Difficulty in navigating new applications and lack of experience in smartphone, tablet, and laptop navigation capabilities).	An individual is entering a County mental health clinic for the first time or taking the assessment alone. As part of the check-in procedures, the individual is asked to complete the web-based screening tool on their phone (or provided tablet) to expedite and/or inform the clinical intake/assessment person, or to advise the individual of resource options.	The individual is "warmed up" to the clinical assessment process with exposure to mental health screening questions and subsequent results. Additionally, the clinician and individual can review the results in order to expedite the treatment plan by reducing redundancy with clinician intake procedures.
 Description: Community Service Provider conducting outreach activities Technical Competency: High (Fully capable in navigating new applications and in the use of smartphone, tablet, and laptop navigation).	A community service provider performing education and outreach activities can utilize this screening tool with clients/participants expressing urgent needs for services for themselves or their clients.	The community service provider is equipped with an education and referral tool to assist individuals in need, while the individual is educated on symptoms and local resources.

Purpose of RFP for Services

To better meet the increased demand for services, MCBH and LACDMH have proposed the development of a comprehensive web-based mental health assessment application that can screen for a broad spectrum of mental health disorders and refer individuals to the appropriate level of care within the local mental health services system. MCBH and LACDMH are soliciting responses to identify and select a vendor to design and develop an evidence-based assessment tool comprising a series of questions that provide the user with an assessment score in a variety of mental health categories. Following the assessment, the

type and severity of mental health symptoms will be identified along with corresponding treatment program options that best fit their needs. The tool will be developed around the core criteria of:

- Being able to screen for a broad range of disorders, from low risk with mild need to severe with urgent need.
- Being easily accessible for use by community-based providers to help individuals acquire treatment.
- Maintaining confidentiality standards.
- Working fluidly in Spanish.

Build upon current evidence-based screening tools with proven validity and utilize item response theory to minimize the number of questions and time involved in the assessment.

Project Scope Overview

This project will be executed across two (2) key phases; DESIGN and TECHNOLOGY for the vendor. The IMPLEMENTATION phase will be a multi-organization effort coordinated at CalMHSA in conjunction with the Design and Development phases. There is a Scope of Work for each Design and Technology phase. A proposing firm must propose for the Scope of Work for both phases.

Example 1: Project Scope

The entire scope of services outlines the design, development and implementation

Design Scope of Work

This Scope of Work will rely on best practice knowledge of research-based tools for mental health diagnosis. The goal of this phase is to design a sound and effective self-assessment that an individual can take on their own, that will direct the consumer to additional resources and options based on the conclusions drawn from the assessment. This screening tool must contain business rules and question trees, guiding the user to answer questions relevant to them based on indicators. The vendor will include clinical and design subject matter experts.

The screening tool must meet the following requirements:

1. Screening tool with questions and answers drawn from existing best-practice and standard behavioral health assessment tools
2. Leverage non-proprietary open source tools in combination with adjustments as needed
3. Avoid duplication of questions if multiple tools are leveraged
4. Lead to possible condition identification in the following areas (at minimum):
    a. Depression
    b. Bipolar Disorder
    c. Schizophrenia
    d. Psychosis
    e. PTSD
    f. Anxiety Disorders
    g. Substance abuse disorders
5. Be written in English and Spanish
6. Result in recommendations for appropriate local mental health resource information.
7. Result in descriptions of the possible condition with informative information
8. Require a User Agreement to be acknowledged by end Conduct Research

The services under this Scope of Work must include the following components of developing this tool:

1. Research
2. Design
3. Evaluation and Refinement

Deliverables

#	Deliverable
1	Project Plan & Schedule
2	Conduct Research
3	Functional Design Document
4	Testing Plan
5	Training Materials

The scope of services is to design a screening tool that allows individuals to take self-assessment, that will lead to a possible condition identification and make soft referrals to supporting agencies within Monterey County and Los Angeles County. The Scope of Services is to involve the following key tasks:

Deliverable 1 - Develop Project Plan & Schedule

a. Plan should include plan for each design key project task, phase, and deliverable
b. Plan should include a design phase project schedule, work breakdown structure, resources, risk management plan, quality plan, change management plan, and project escalation path for the design phase of the project.

Deliverable 2 - Conduct Research

c. Research should include analysis of existing tools, studies of self-assessments, as well as research and interviews of stakeholders and County staff in coordination with CalMHSA

Deliverable 3 - Functional Design Document

d. Create a design document in collaboration with the Technology Services Provider to outline relationships between functionality and design requirements including workflows through the screening process
e. As part of this proposal submittal, provider is to submit a range of time which the assessment tool is estimated to be completed by the user. For example: "The full assessment tool is estimated to take between x minutes (minimum) and y minutes (maximum) to complete". Consideration should be made to design an assessment tool that is extensive enough to deliver an effective outcome, but not so exhaustive that users fail to complete it due to an excessively lengthy process. Please provide an estimation of time it would take an end-user to complete the assessment.

Deliverable 5 - Training Materials

f. A cohort of CalMHSA, County staff and community-based service providers will be trained in the use of the tool. Similar user-testing may take place in Los Angeles as well. These trained individuals will then pilot screenings in the field, using the application with a small number of clients to ensure its applicability in their local communities, and assess functionality and user experience. The goals of the Evaluation Phase will include:

    - Determine if this screening tool accurately gauges type and severity of mental illness.
    - Determine if this application provides meaningful and accurate referral connections to the appropriate service / resource as efficiently as possible.

- Assess whether this screening tool reduces the hours and cost associated with in-person assessments.
- Assess whether individuals (staff, community provider, peer, etc.) using this application to assist a person in need find this application useful for connecting that person to resources.
- Assess the impact the implementation of this application has on the total volume of clients entering services including its effect on the demographics of clients served.

The evaluation phase will include both steps for validation and refinement as identified below:

1. Validation
    a. Validation of the tool should involve dissemination of the screening tool to Monterey and Los Angeles residents and staff
    b. Monterey and Los Angeles staff engage with local Community Based Organizations to assist with the dissemination of the screening tool
    c. The vendor shall create the validation plan
2. Refinement
    a. Work collaboratively with CalMHSA, Monterey and Los Angeles Counties to modify and refine the assessment tool after input has been received.
    b. The vendor shall participate in and facilitate the refinement plan

Technology Scope of Work

This phase will rely on a team of technologists to build or configure a mobile compatible web-based questionnaire screening tool which results in a possible condition and soft referrals based on business rules and information as developed in Phase 1.

Vendors should describe the delivery model along with the advantages. Delivery models considered for the required solution may include:

- Commercial off-the-shelf (COTS) software
- Custom built application
- Open-source software (all models)
- Managed services/hosted

The output of this scope of work must include a solution that:

1. Is a responsive web design with the ability to adapt easily across all devices (i.e. desktop, laptop, mobile, etc.)
2. Is on cloud-based infrastructure within cloud instances
3. Is compliant with HIPAA, PHI, PII and other modern security standards

including being compliant with FedRAMP Medium standards to include a third-party assessment of the security standards to ensure compliance with these standards

4. Provides the ability to function consistently across multiple browsers (i.e. Edge, Chrome, Safari)
5. Uses business requirements and business-rules to drive functionality as defined by the Design Scope of Services
6. Captures all assessments and any other required data as identified from the section above (Design Scope of Work)
7. Does not require individual licensing fees
8. Supports multiple languages (i.e. Spanish and English) as identified by participating counties
9. Is intuitive and user friendly
10. Identifies possible condition(s) as defined by the Design Scope of Services
11. Provides the capability to enter, maintain and display local service providers as defined by the Design Scope of Services
12. Complies with ADA and WGAG v2.x or latest
13. Seamlessly scalable to accommodate future growth
14. Supports standard APIs, interfaces, and communication protocols for enterprise application integration systems and/or web services integration to other applications (integration not in scope of this contract). This Scope of Work will not be used to capture consumer health data or to submit claims.
15. Allows individual counties to easily access their respective data for reporting and other business purposes
16. Supports administration of application (i.e. user access control, define user roles, security, maintain lookup tables, etc.)
17. Supports business intelligence and analytical tools

Deliverables

The services executed in this phase should be conducted in an Agile methodology. This phase will initiate before the screening tool has been developed and will require a team to implement screens and business rules. Development efforts in this phase will also require working closely with CalMHSA, in collaboration with Monterey County and Los Angeles County to validate the look and feel of screens, needs for data security and management, and build a platform that could in the future integrate with Monterey and Los Angeles internal systems.

#	Technology Deliverables
1	Technical Documents
2	Application Landscape/Environments
3	Application Prototype

4	Test Strategy and Documents
5	Training Strategy and Documents

6	Production Deployment
7	Post-Go Live Support
8	Data Extracts
9	Status Reporting
10	System M&O

Development or configuration of the application in a Cloud environment using iterative development practices.

Deliverable 1 – Technical Documents

Technical documentation including architecture and code base referenced directly to functional requirements, as well as any hosting or maintenance needs.
Technical documents must include the following:

- Functional Design Document
- Technical Design Document
- Application/System Architecture Document
- Entity Relationship Diagram (ERD)
- Application Workflow
- Data Dictionary

Vendor team shall provide a technical design document, which includes the above listed documents.

Acceptance Criteria

The CalMHSA will accept the completion of the Technical Document per the following acceptance criteria:

1. Business Requirements Document should list all the user stories and requirements and business rules in detail along with any future or enhancement requirements.
2. Technical Requirements document that comprehensively lists the technical details i.e. screen names, field names, data types (numeric vs alphanumeric), etc. This document should also list all the security requirements to comply with various County, state and Federal security policies.
3. Technical Design document that includes user interfaces, wire frames, data flow diagrams, etc.
4. Application System Architecture document that includes Conceptual, Logical Architecture
5. Entity Relationship Diagram should include the table structures and their relationships and dependencies

6. Application workflow should include a detailed flow diagram of the various functions
7. Data Dictionary document that lists all the data fields and their attributes
8. The design document should also include any designs for features not-yet developed, including the relevant Epics, Features, and User Stories.

Deliverable 2 - Application Landscape/Environments

The project should provide the standard application code development/maintenance landscape i.e. Development, Test and Production environments.
Note on Test Environment: Vendor shall provide a test environment specific to the County so that county staff and Peers can test configurations and feature development in a manner that reflects their Production Environment.

Acceptance Criteria

1. A Test Environment that mirrors the Production Environment, but also includes county specific configurations that is accessible through a County Code.
2. The Test Environment should be completely separate from the Production Environment. There should be no way for a user in the Test Environment to be transferred to the Production Environment and vice versa.

Deliverable 3- Application Prototype

The vendor shall develop a working functional prototype of the end state application to be approved by the CalMHSA, Monterey and Los Angeles teams.

Deliverable 4 - Test Strategy and Documents

The vendor shall provide an overall test strategy document along with the following documents:

- Functional Testing Document and test scripts
- Technical testing document and test scripts
- User Acceptance testing document and test scripts
- Integration testing document (if needed)
- Regression testing document (if needed)

The Vendor team shall conduct testing on all developed features, bug fixes, and configurations, and resolve all issues, before code changes are deployed to County test environment. The Vendor team shall report to the CalMHSA Project Manager findings from testing on a regular basis.

UAT Entry Criteria

1. Vendor notifies CalMHSA of any development work performed outside of the Tech Suite that affects county configured environments. (During Sprint Planning)

2. Automated and Manual testing report provided by Vendor
3. Release notes have been provided to CalMHSA by Vendor
4. New features and defect fixes have been migrated to the Test Environment

Acceptance Criteria

1. Any feature developed in the Test Environment pass Regression Testing and User Acceptance Testing prior to being able to deploy into the Production Environment
2. All identified bugs are shared with CalMHSA and ultimately resolved by provider
3. CalMHSA and County Sign-Off on items that pass User Acceptance Testing prior to deployment to the Production Environment

Deliverable 5 - Training Strategy and Documents

The vendor shall provide a detailed training strategy document (i.e. train the trainer, on-site/classroom training, etc.) along with the necessary training materials - Administrator Guides, User Guides, Cheat Sheet, etc. The vendor shall conduct the necessary training as outlined in the training strategy document.

Deliverable 6 - Production Deployment

The vendor shall deploy and configure the application with agreed upon functionality (including any bug fixes and enhancements) in production environment and make it available for production use.

Acceptance Criteria

The CalMHSA will accept the completion of this deliverable with the completion of the following conditions:

1. Working and stable Production Environment is accessible by County with county code
2. Vendor will not push changes to Production that also affect County configured environments without prior approval
3. Production Environment contains all code approved by CalMHSA from Testing Environment for MVP & Configuration needs
4. Production Environment reflects approved Configuration
5. CalMHSA Sign-Off on Production Environment

Deliverable 7 - Post Go-Live Support

The vendor shall provide technical and functional support for 180 days after full production rollout of the application.

Deliverable 8 - Data Extracts

Vendor shall provide the county with periodic data extracts which can be used to support the evaluation of the effectiveness and accuracy of the tool. Data extracts must be part of the product used for testing so that the Design Vendor can assess the effectiveness of the solution. Data extracts must also be available post testing phase and during Go Live so that the system can be continuously evaluated.

Acceptance Criteria

1. Reports will be continually accessible to CalMHSA, County and Design Vendor for evaluation purposes.

Deliverable 9 – Status Reporting

Vendor shall provide the following deliverables per contract requirements:

1. Mechanism for clients to obtain accounting of disclosures of Personally Identifiable Information (PII)
2. Outcome dashboard*
3. Quarterly Status of Deliverables report*
4. Annual Status of Deliverables report*

*These items are to be maintained and reviewed on an ongoing basis.

Deliverable 10 – Maintenance & Operations

This section outlines expectations of the Vendor team to support and maintain a working environment for Vendor users. All features must be maintained to continue meeting acceptance criteria. It is required that CalMHSA will be the sole owner of the application in its Help@Hand form without recurring licensing fees.

Vendor team shall also provide a platform maintenance fee structure for ongoing rollout after MVP (e.g. by bands of users; by number of growth paths completed, etc.).

Agreement Terms

The Agreement will be for one year, and is subject to fund availability. If it is determined funds are no longer available, the Agreement may be terminated without cause or penalties.

The Agreement shall reflect a deliverable based payment structure not to exceed $2.1 million. Respondents are asked to provide a detailed estimate of scope and cost necessary to achieve the goals detailed in the Scope of Work of the Technology development component.

The resulting Agreement will not take effect until fully executed by all parties and all insurance requirements have been met.

Response Contents

The following response components are required as outlined below. CalMHSA is not responsible for costs associated with the development of proposals nor shipping or delivery of such.

Response Contents – General

Please submit the following components as part of your response:

1. Cover Letter (limit 1 page)
2. Background of organization
    a. Describe how your organization is equipped to meet the needs as identified in this Scope of Work and provide three examples of prior work that is similar in scope and complexity to the items outlined in this Scope of Work (limit 4 pages)
    b. Executive Summary of proposed team and organizational structure, including all required key positions and any additional proposed positions (limit 6 pages)
    c. Resumes
        i. Design Staff
        ii. Technology Staff
        iii. Any Additional Staff
    d. Understanding and Approach (limit 30 pages)
3. The vendor must propose a project management tool that will be accessible by CalMHSA and County staff
4. Cost Proposal
    a. The vendor must download and submit a complete "Cost Worksheet" excel file found in Bonfire under "Files."
5. Conflict of Interest Policy
    a. The vendor must download and submit a fully executed "Conflict of Interest Policy." This document can be found in Bonfire under "Files."
6. Proposal Submittal Letter
    a. The vendor must download and submit a fully executed "Proposal Submittal Letter" on their letterhead. This document can be found in Bonfire under "Files."

Response Contents - Design

1. Proposed Team
    a. Identify qualifications of resources for the following key roles
        i. Project Manager
        ii. Lead Researchers
        iii. Identify any additional roles as necessary to complete the Scope of Work

iv. Include resumes for each proposed team member

2. Approach to Scope of Work
    a. Outline approach for conducting all activities related to the Scope of Work
    b. For each task, identify key activities, milestones, deliverables, and work plan
    c. Describe process for maintaining quality of deliverables
    d. As part of this proposal submittal, provider is to submit a range of time which the assessment tool is estimated to be completed by the user. For example: "The full assessment tool is estimated to take between x minutes (minimum) and y minutes (maximum) to complete". Consideration should be made to design an assessment tool that is extensive enough to deliver an effective outcome, but not so exhaustive that users fail to complete it due to an excessively lengthy process.
3. Cost Proposal
    a. Outline each proposed resource, estimated hours per task, and rate used to calculate estimated cost
    b. Define total proposed cost
    c. Contract shall be paid on deliverables
    d. Cost proposal details must be submitted on the Cost Worksheet (Exhibit 1)

Response Contents - Technology

1. Proposed Team
    a. Identify qualifications of resources for the following key roles
        i. Development Manager / Scrum Master
        ii. Lead Developer
        iii. Developer
        iv. Identify any additional roles as necessary to complete the Scope of Work
        v. Include resumes for each proposed team member
2. Approach to Scope of Work
    a. Outline Agile development approach for conducting all activities related to the Scope of Work
    b. For each task, identify key activities, milestones, deliverables, assumptions, and work plan not to exceed 15 months for the Design and Development phases
    c. Describe process for maintaining quality of deliverables
3. Cost Proposal - Services
    a. Outline each proposed resource, per the Cost Worksheet provided in Exhibit 1.
    b. Define total proposed cost
4. Cost Proposal - Materials
    a. Outline the cost to CalMHSA for the environment and other development costs
5. Cost Proposal – Maintenance and Operations – 1 year
    a. Outline the approach to Maintenance and Operations for 1 year to begin directly after implementation of the system on the first day that the system goes live
    b. 1 year of Maintenance and Operations to be included in the overall project and

cost

c. Include details of staff, services, and materials and platform maintenance costs

Roles and Responsibilities

This outlines the roles and responsibilities for each phase of the project.

Design Services

1. Provide overall project management and oversight to the project
2. Create and delivery monthly status reports
3. Facilitate weekly Status meetings and Daily Standups
4. Provide a path for escalation of issues
5. Facilitate and organize meetings with CalMHSA, MCBH, and LACDMH
6. Review deliverables for quality before submission to CalMHSA, MCBH, and LACDMH
7. Create and document survey questions and business rules
8. Document and identify source and rationale for specific questions and logic implemented
9. Work collaboratively with CalMHSA, MCHB, LACDMH, and Technology Vendor throughout the design and validation process
10. Communicate any schedule delays, risks, and mitigation strategies throughout the project
11. Report to the CalMHSA project manager and the MCBH and LACDMH project managers
12. Maintain compliance with research process regulations and engagement with people for the evaluation phase
13. Work collaboratively with all teams

The vendor must utilize an actively licensed psychiatrist as part of the Design team

Technology Services

1. Communication of anticipated or unanticipated risks, delays to the CalMHSA Project Manager
2. Engaging in meetings with CalMHSA and County staff including Daily Standups for the purposes of presenting product demos, validating requirements, assist with design decisions, and general project coordination
3. Establishing clear validation of product and configuration requests
4. Execution of all testing and regression testing to ensure product changes, enhancements, bug fixes, and configurations are developed in accordance with acceptance criteria and do not create new defects
5. Communication and resolution of major faults identified in Production
6. Communication and resolution of down time, blocking issues, and incidents
7. Monitoring of application performance
8. Application security and HIPAA compliance
9. Accessibility and ADA Compliance
10. Spanish and English Language processing

11. Monitoring and maintenance of SLAs

12. Completion of all deliverables identified in the above sections
13. Coordinate meetings and requests through CalMHSA Project Manager
14. Responsive to CalMHSA requests in a timely manner
15. Provide data as needed to Evaluator as related to assessment of product use
16. Provide a solution to support assessment of different types of users; users who were marketed to in different areas, with different materials, or different target populations

Counties of Monterey (MCBH) and Los Angeles (LACDMH)

1. Provide County specific clarification and direction
2. Provide final sign-off of development iterations
3. Participate and sign-off on all primary testing components per the proposed testing and approval methodology

CalMHSA

The CalMHSA as the contract holder, takes responsibility for the following key components:

1. Identify a stakeholder / sponsor individual who can provide "Sign-Off" and make key project decisions
2. Provide a staff who will fill the role of the Product Owner (Voice of the Customer), provide acceptance criteria and accept deliverables
3. Identify a project working team to provide feedback and work with vendor teams
4. Participate in daily standup meetings
5. Coordinate through CalMHSA for vendor requests
6. Participate in testing and provide staff to conduct testing when code is deployed to the test environment
7. Review deliverables and provide feedback in a timely manner
8. Provide overall management of Scope, Timeline and Deliverables
9. Coordinate meetings, work sessions, risks, and documentation
10. Facilitate project decisions with County
11. Provide an escalation path for MCBH and LACDMH
12. Complete User Acceptance Testing (UAT)

Submission Instructions and Requirements
Proposal Timeline

EVENT	Key Dates
RFP Issued	January 11, 2021
RFP Questions Due	January 22 5:00pm PST
Bidders Conference	January 28 9:00am PST
RFP Questions Answered	February 4 5:00pm PST
Deadline for Intent to Bid*	February 8, 11:59 pm PST
Deadline for Proposals to be Submitted	February 18 5:00pm PST
Application Review	Feb 19 –Mar4, 2021

*To meet the Deadline for Intent to Bid requirements, potential vendors must check the "intent to bid" box within the Bonfire Portal. Vendors will not be able to submit proposals if this box is not checked by the deadline.

Submittal Address

All Submissions must be submitted electronically using CalMHSA's e-Procurement Portal: https://calmhsa.bonfirehub.com/.

RFP Questions and Clarifications

All questions and requests must be submitted through CalMHSA's e-Procurement Portal at: https://calmhsa.bonfirehub.com/. The deadline to submit questions for this RFP is January 22, 2021, 5:00 pm PST. The FAQ responding to the questions will be posted on February 4, 2021, 5:00 pm PST at https://calmhsa.bonfirehub.com/ and to the CalMHSA website at www.calmhsa.org.

To ensure all parties have access to the same information at the same time, except as stated below, CalMHSA will NOT respond to questions as they are received and will not accept telephonic questions. CalMHSA will not send out emails following the posting of the FAQ. It is the sole responsibility of the proposer to refer to the FAQs, which will be posted on CalMHSA's e-Procurement Portal at https://calmhsa.bonfirehub.com/.

If a Proposer is unable to submit questions via the Bonfire e-Procurement Portal, the Proposer must provide CalMHSA with an email justification outlining why the Proposer is unable to do so.

Bidders Conference

The Bidders Conference will be held on January 28, 2021 from 9:00AM-11:00 AM via Zoom. The meeting invite will be posted on the CalMHSA website and a link is included here. A recording of the Bidders Conference will be posted to the Bonfire Portal and CalMHSA website by January 29, 2021, 5:00 pm PST. The Bidders conference meeting details are as follows:

Join Zoom Meeting
https://us02web.zoom.us/j/84828010341?pwd=RGlzb1M2M2FqV1lRMWJHc0VKQTBRdz09
Meeting ID: 848 2801 0341
Passcode: 254088
Dial by your location
+1 669 900 9128 US (San Jose)
+1 346 248 7799 US (Houston)
+1 253 215 8782 US (Tacoma)
+1 301 715 8592 US (Washington D.C)
+1 312 626 6799 US (Chicago)
+1 646 558 8656 US (New York)
Find your local number: https://us02web.zoom.us/u/kcO3tknpBt

Withdraw

A proposer may withdraw or amend its proposal, but only before the Application Submittal Deadline, directly on CalMHSA's e-Procurement Portal at https://calmhsa.bonfirehub.com/.

Review of Applications

CalMHSA will receive all applications and review for completeness and adherence to the RFP rules stated in this document. Following the initial review, all qualified applications will be reviewed and scored by a review panel. The evaluation panel will conduct a fair and impartial evaluation of proposals received in response to this RFP.

The review panel is comprised of individuals with varied backgrounds, to include professional expertise, lived experience, personal knowledge, etc. Panelists' information will not be disclosed as a matter of confidentiality. CalMHSA is committed to ensuring the RFP review panel is representative of California's racial, ethnic, and cultural diversity.

Responses will be reviewed and scores awarded on the following best value considerations:

- Understanding and Approach – 40%
- Staffing and Organization – 30%
- Cost – 30%

Non-Collusion

A proposer shall not conspire, attempt to conspire, or commit any other act of collusion with any other interested party for the purpose of secretly, or otherwise establishing and understanding regarding rates or conditions to the solicitation that would bring about any unfair conditions.

Negotiations with Potential Proposers

Selection will not be based exclusively on price. CalMHSA reserves the right to negotiate with proposers who, in the opinion of the review panel, have submitted the best proposal in an attempt to reach an agreement. If no agreement is reached, CalMHSA may negotiate with other proposers or may choose to extend the proposal period. CalMHSA also reserves the right to meet with vendors to gather additional information. Additional information may include, but is not limited to, a demonstration of skills described in the proposal.

Protest Procedures

Protests must be received no later than five (5) business days after the Notice of Intent to Award is posted on the CalMHSA website. The sole bass for protest are that the award was (1) in violation of law, (2) in violation of the provisions of this RFP, or (3) in violation of CalMHSA's procurement process. All protests must be in writing and (1) state in detail each and every ground asserted for the protest, citing to the law, RFP provision, or particular provision of the procurement policy on which the protest is based; (2) explain why the error prevented the aggrieved organization from being awarded the contract; and (3) identify the remedy sought.

Within 14 days of receipt of any protest, CalMHSA's Executive Director will provide a written decision which shall be final upon transmission to the protesting party. If the Executive Director determines that the error identified by the protesting party has deprived that party from receiving the contract, the Executive Director may act to rectify the error, including but not limited to cancellation of the RFP or proposed contract, correction or other revision of the awarded contract, termination of an improperly awarded contract, or affirmation of an existing contract if the discovered defect is immaterial or the Executive Director determines that affirmation is in the best interest of CalMHSA.

Notice Regarding Public Records Act Request

CalMHSA is subject to the Ralph M. Brown Act and the California Public Records Act. All proposals received for this RFP are ultimately subject to public review; however, during the competitive bid process, all proposals will be kept confidential. Upon award and execution of contract by awardee(s), all proposals and supplemental information will be subject to public review, with the exception of those elements of a proposal which contain elements that are clearly marked as confidential or trade secrets. Any such designation should be accompanied by a brief explanation of the reason the information is non-public and protected from disclosure under California law. CalMHSA reserves the right to disregard such designations if they have been applied indiscriminately to non-protected information, and in no

event shall CalMHSA, its agents, representatives, consultants, directors, or officers be liable to a responding party for the intentional or inadvertent disclosure of all or a portion of a proposal submitted under this RFP, regardless of whether it was marked as confidential or trade secret.

Although the California Public Records Act allows certain confidential or trade secret information to be protected from disclosure, CalMHSA may not be in a position to establish that the information submitted is protected. If CalMHSA receives a request for public disclosure of all or any portion of a proposal that has been designated as exempt from disclosure, CalMHSA will use reasonable efforts to notify the responding party of the request and give such party an opportunity to assert, at its own expense, a claimed exception under the California Public Records Act or other applicable law within the time period specified in the notice issued by CalMHSA and allowed under the California Public Records Act.

Format of Proposal

Proposals must be submitted through CalMHSA's e-Procurement Portal at:
https://CalMHSA.bonfirehub.com/.

Internet Explorer 11, Microsoft Edge, Google Chrome, or Mozilla Firefox. Javascript must be enabled. Submissions by other methods will not be accepted.
Browser cookies must be enabled. Respondents should contact Bonfire at Support@GoBonfire.com for technical questions related to submissions or visit Bonfire's help forum at:
https://bonfirehub.zendesk.com/hc.

Submission materials should be prepared in the file formats listed under Requested Information for this opportunity in the Bonfire Portal. The maximum upload file size is 1000 MB. Documents should not be embedded within uploaded files, as the embedded files will not be accessible or evaluated.

Submission documents must be in 12-point font in Times New Roman, single spaced. Exhibits

included herein by reference:

Exhibit 1	Cost Worksheet
Exhibit 2	CalMHSA 2020 Conflict of Interest
Exhibit 3	Proposal Submittal Letter

Appendix B. Vendor (CredibleMind) Scope of Work

Statement of Work - Monterey / LA

VENDOR: CredibleMind
WORK FOR: Monterey County / LA County
PROJECT TITLE: Help@Hand Screening Application

Schedule:
Start Date: August 2, 2021 Completion Date: May 31, 2023

Description of Project and Subcontractor Services:
To better meet the increased demand for services, MCBH and LACDMH have proposed the development of a comprehensive web-based mental health screening application that can screen for a broad spectrum of mental health disorders and refer individuals to the appropriate level of care within the local mental health services system.

CredibleMind, Inc. will develop an evidence-based screening application comprising a series of questions that provide the user with screening application results in a variety of mental health categories. Following the screening, the type and severity of mental health symptoms will be identified along with Help@Hand CalMHSA, Monterey County and Los Angeles County 7 corresponding treatment program options that best fit their needs. The application will be developed around the core criteria of:

- Easily accessible to individuals 18-years and older seeking mental health services as well as family members or friends supporting an individual experiencing symptoms of a mental health disorder
- Being able to screen for a broad range of disorders, from low risk with mild need to severe with urgent need.
- Lead to possible condition identification in the following seven areas (at minimum): a. Depression b. Bipolar Disorder c. Schizophrenia d. Psychosis e. PTSD f. Anxiety Disorders g. Substance abuse disorders
- Provides education on symptoms, associated risks, treatment options, and local resource information and whenever possible, and if desired by CalMHSA, high-quality self-help resources as determined by CredibleMind's credibility algorithm to individuals as well as family and friends supporting an individual
- Screening application results are easily accessible for use by community-based providers to help individuals acquire treatment.
- Maintaining confidentiality standards.
- Working fluidly in Spanish. Build upon current evidence-based screening tools with proven validity and utilize item-response theory to minimize the number of questions and time involved in the screening application.

Subcontractor will provide CalMHSA with the following Services and/or Deliverables:

Services	Key Deliverables (be descriptive)
Resourcing	Provide a dedicated team supplemented with advisors and consultants who are already engaged with CredibleMind or who have agreed to join the team for this project. Resources will include experts in psychiatry and psychology, user interface design, research, evaluation, and technology as outlined in the vendor proposal, making this project, CredibleMind's top priority.
1.0 Project Plan & Schedule ● Conduct Kick-Off Meeting with all project teams from CredibleMind and CalMHSA ● Meetings with each sub-group ● conducted ● Draft initial project plan ● Draft final project plan	Deliver project plan 4-weeks after signed contract: 1. Project kick-off meeting completed 2. Project plan and schedule initiated 3. Consultation with Technology team completed 4. Initial project plan and schedule completed pending required deliverables for Task 1.1
1.1 Develop a design-phase project schedule, work breakdown structure, resources, risk management plan, quality plan, change management plan, and project escalation path for the design phase of the project	1. Design-phase project schedule 2. Work breakdown structure 3. Resources 4. Risk management plan 5. Quality plan 6. Change management plan 7. Project escalation path for the Design phase Above will be delivered through the following milestones: 1. Initial project plan and schedule completed 2. Consultation with Technology team on additional plan components completed 3. Final project plan and schedule completed 4. Final project plan and schedule distributed and approved by CalMHSA
2.0 Research Plan	Deliver overall research plan inclusive of approach and timeline 4-6 weeks after project plan.
3.0 Conduct Research Conduct a literature review of original research to document the evidence base on mental health screening tools and studies of self-assessment tools by age and language groups, and comparing effectiveness of virtual with in-person, or other approaches and their associated costs	(Estimated to take 12-16 weeks) Comparative analysis of evidence-based self-assessment and screening tools (virtual, in-person, other) for children and adults in English and Spanish and their associated costs through the following milestones: 1. Requirement review meeting with CalMHSA 2. Scoping literature review completed 3. Final report of the literature review completed
3.1 Collaborate with expert psychiatrists and psychologists to identify existing screening tools on websites and through	List of evidence-based, non-proprietary, open-source clinical assessment and screening tools for outcomes of interest in English and Spanish with completion of the following milestones:

Google and Google Scholar search and identify the best practices for self-administered screening tools with good psychometric properties that are available in English and Spanish for target conditions in children and adults	1. Requirement review meeting with CalMHSA completed 2. Environmental scan/literature review completed 3. Final report and list of tools completed
3.2 Needs assessment, stakeholder interviews and potential patient and family member/friend focus groups in coordination with CalMHSA, and Monterey and LA Counties	Deliver analysis of interview responses which will address the following research goals: a. The perception of need from mental health and behavioral health agencies, the patients, and their family members/friends b. The barriers and facilitators to accessing mental health information, screening, and services c. The perception and community preferences of using technology for mental health screening and access from providers, patients, and their family members / friends. Cost considerations for implementation of various types of virtual screening tools Through completion on the following milestones: 1. Identified stakeholders for interviews and focus groups 2. Stakeholder interviews and focus groups completed 3. Interview report and needs assessment results delivered
3.3 Map the county behavioral health system through monitoring the county populations served and population trends, types of services offered, and key performance measures for behavioral health	List of key populations served and in need of services for each county, most common mental health conditions, existing services and associated costs for accessing mental health services, and key behavioral health performance measures through completion of the following milestones: 1. Requirement review meeting with CalMHSA completed 2. Mapping county behavioral health systems completed 3. Final report of behavioral health system maps for each screening application condition in each county instance
4.0 Functional Design Document Collaborate with the Technology Services Provider on design document	Within 12-weeks after research completed, provide a design document that outlines relationships between functionality and design requirements including workflows through the screening process and completion of the following milestones: 1. Design document initiated with Technology Services Provider 2. Design document completed
4.1 Create a draft of questions for the screening application using screening tools collected to conduct research and analysis. Remove any duplicated questions.	Deliver a version of the comprehensive web-based mental health screening application ready to be tested in the validation and evaluation components of the Design phase. Screening application will address the seven conditions listed in the project descriptions at a minimum and will include demographic questions that would branch to condition subtypes if relevant to the user as well as questions from validated, non-proprietary scales that assess social

	determinants of health, such as social support and neighborhood effects. Deliver draft of screening application questions though completion of the following milestones: 1. Draft of screening application questions completed in English and translated in Spanish 2. Internal user testing completed (in English and Spanish) 3. Internal QA testing completed
4.2 Conduct design sprints	Delivery of the following: 1. User personas 2. Onboarding prototype 3. Application prototype with questions and results 4. Prototype of ability for provider to access patient/user results Through completion of the following milestones: 1. User journeys developed 2. Usable application prototypes designed 3. User tests conducted 4. Application prototypes revised and approved
4.3 Conduct user testing to determine a range of time which the screening application is estimated to be completed by the user	Deliver user testing results to determine whether the screening application is extensive enough to deliver an effective outcome, but not so exhaustive that users fail to complete it due to an excessively lengthy process. Completion of the following milestones: 1. User testing script completed in English and translated in Spanish 2. Participants for user testing recruited (English and Spanish speakers) 3. User testing sessions completed (2 rounds for English and 2 rounds for Spanish. Each language will include 2-3 user testing sessions per round) 4. User testing findings summarized
4.4 Based on user testing results, refine screening application as needed and finalize a version to use for training materials	Final estimation of time it would take an end-user to complete the screening application (to be within 10-25min) through completion of the following milestones: 1. Screening application refinement completed if necessary. 2. Estimated time to complete finalized and distributed
5.0 Testing Plan and Validation Create a validation plan for dissemination of screening application to Monterey and LA residents and staff	(Estimated to take 8-10 weeks) 1. Validation specification meetings completed 2. Validation plan completed 3. Validation plan approved 4. Validation plan distributed 5. Validation on most recent supported versions of all major browsers (Microsoft Edge, Chrome, Firefox and Safari)
5.1 Conduct a validation study with user testing in Monterey and LA Counties	Provide a validation plan and validation study results and recommendations based on the completion of the following: 1. Recruit participants of various age groups, educational backgrounds, and various racial and ethnic groups, also making sure to include native Spanish speakers

	2. Validation kick-off meeting completed for requirement gathering 3. Validation study plan delivered and approved 4. Validation study completed 5. Validation report completed (including recommended revisions)
6.0 Training Materials: Create, Test and Distribute Create training materials for the cohort of CalMHSA, County staff and community-based providers for use of the screening application, test the materials in the field, revise based on feedback and distribute as needed	(Estimated to take 6-8-weeks) Deliver training materials for CalMHSA, County staff and community-based service providers 1. Draft training documents 2. Pilot training validation report 3. Final training documentation 4. Final training validation report Through completion of the following: 1. Initial training materials completed 2. Initial pilot training conducted 3. Final training conducted 4. Training materials updated based on validation and feedback 5. Electronic and printed training materials distributed
Distribute the screening application for initial piloting and use during training validation phase	Provide distribution plan and report through completion of the following: 1. Distribution plan approved 2. Distribution of screening application initiated 3. Distribution of screening application completed
7.0 Application Development	Develop and deliver mental health screening application inclusive of iterative updates and enhancements based on feedback and validation studies.
8.0 Technical Documents ● Create and update themes and features ● Write user stories and acceptance criteria per feature ● Confirm and elaborate user workflows from mockups ● Create technical design ● Create data design ● Document app/system architecture ● Document ERD ● Access and output compliant with HIPAA, PHI, PII and other modern security standards including being compliant with FedRAMP Medium standards to include a third-	(Within an estimated 6-weeks) Provide the following 1. Business Requirements Document 2. Functional Design Document 3. Technical Design Document 4. Application/System Architecture Document 5. Entity Relationship Diagram (ERD) 6. Application Workflow 7. Data Dictionary Through completion of 1. Mockups approved 2. Business Requirements Document approved 3. Functional Design Document approved (in collaboration with the Design team) 4. Technical Design Documents approved

party assessment of the security standards to ensure compliance with these standards	
9.0 Application Landscape / Environments ● Configure environments ● Setup test accounts ● Setup test environment security ● Configure environment monitoring ● Configure Sentry Error Logging ● Configure analytics	(Within an estimated 3-weeks) Deliver configured environments and access instructions through completion of the following: 1. Deliver test and production environments 2. Deliver access instructions
10.0 Application Prototype ● Review design ready user stories and size level of effort ● Choose release sprint targets ● Plan development sprint by scheduling user stories and assigning to developers ● Develop features and assign to QA ● Perform QA and assign to Product for UAT a. Perform UAT and schedule for Sprint Demo b. Conduct Sprint Retrospective c. Repeat sprints until application complete	(Within an estimated 16-weeks) Complete Continuous Application Deployment to Development and Staging as new builds and functionality is completed Functional and Technical Design Documents (updated as needed) through completion of the following steps: 1. Initial development sprint tasks defined 2. Critical mass of MVP Features Approved 3. MVP Released 4. Features pass unit testing and QA testing 5. Features pass UAT 6. Stakeholder Platform Functionality Acceptance
11.0 Test Strategy, Ongoing UAT and QA ● Resolve automated issue detection ● Confirm browser and versions for QA ● Conduct User Acceptance testing ● Conduct Functional Testing and Technical Testing ● Conduct Integration Testing (if needed) ● Triage QA Product issues in regular meetings ● Conduct Regression Testing	(Within an estimated 22-weeks) Provide: 1. Unit testing reporting definition 2. QA Triage Process definition 3. Functional Testing Document and test scripts 4. Technical testing document and test scripts 5. User Acceptance testing document and test scripts 6. Integration testing document (if needed) 7. Regression testing document (if needed) 8. Automated monitoring endpoints Through completion of the following steps: 1. Development Sprint QA Ready state achieved 2. Functionality QA Ready state achieved 3. Production deploy QA Ready state achieved

● Implement automated monitoring	
12.0 IT Training Strategy and Documents ● Identify any outside IT responsibilities and document ● Identify internal Site Configuration responsibilities and document ● Identify any DevOps responsibilities and document	(Estimated to take 6-8 weeks in conjunction with 6.0 Training Materials) Once training materials are approved, provide: 1. IT Training Documents by component 2. IT Training Videos (if helpful for explaining) 3. Zoom or in-person trainings (as needed)
13.0 Production Deployment Setup subdomains	(Within 30-days of completing IT training strategy and documents) Provide LA County Instance, Monterey County Instance and necessary Staging Instances. Confirm county instances are accessible.
14.0 Post Go-live Support (Persists 180 days post go-live) ● Engage with additional Project Management for post-deployment if necessary ● Establish feedback and roadmap request channels ● Establish issue resolution process ● Regular check-in meetings	● Assign Project Manager (if different than previous Project Managers for post-deployment) ● Provide forms for submitting change requests ● Schedule regular meetings
15.0 Data Extracts (Persists 180 days post go-live) ● Define final reports from technical documentation ● Define reporting roles (e.g. which people receive and/or access which reports) ● Create data extracts ● Create email reports ● Support for business intelligence and analytical tools Support for administration of the application (i.e. user access control, define user roles, security, maintain lookup tables, etc.)	Project Manager to establish reporting deliverable process per county and pilot site Deliver Data extracts and sample reporting for each county and pilot site Provide consolidated cross-county reporting option for CalMHSA Reports will be continually accessible to CalMHSA, County and Vendor for evaluation purposes.
16.0 Status Reporting (Persists 180 days post go-live)	Through approved privacy policy and outcomes dashboard, provide the following:

● Review Privacy Policy for conformity to disclosures of PII ● Review PII Reporting methods per updated Privacy Policy ● Create outcome dashboard ● Update Quarterly Deliverables Report with Trend ● Update Annual Deliverables Report with Trend	1. Mechanism for stakeholders to obtain accounting of disclosures of PII 2. Outcome dashboard* 3. Quarterly Status of Deliverables report* 4. Annual Status of Deliverables report* *These items will be maintained and reviewed on an ongoing basis.
17.0 Software Maintenance and Hosting	Provide ongoing development and support of the screening application
17.1 Development Software	Maintain licensing required for tools/applications used to develop the screening application
17.2 Production Software	Provide ongoing maintenance and required updates for compatibility and/or regulatory requirements
17.3 Annual Hosting Service	Manage and maintain hosting environment for production and testing environments
18.0 County Implementation and Operations	1. Setting up a county instance 2. Integrate county specific branding (or co-branding with CalMHSA/Help@Hand) 3. Integration of county specific behavioral health providers and services (including ability to get screening results to providers) 4. Raw data reporting to each county including data utilization and assessment results data (through interactive dashboard and/or data download) 5. Integration of county specific screening questions, messaging, and other links besides behavioral health services 6. Project manager — single point of contact for the implementation and operations 7. Self-service training tools (updated as the tool is used and improved) including documentation and videos
18.1 System Maintenance & Operations (M&O) ● Project Manager schedules regular update meetings with county points of contact ● Monitor systems and report issues ● Monitor content quality ● Monitor activities and report outliers	1. Transition to production 2. Steady state responsibilities assigned 3. Report of resolved performance issues 4. Report of resolved content issues 5. Report of resolved user activity outlier issues

19.0 Independent Evaluation and OAC Report CredibleMind will hire an Evaluation Team to conduct an independent outcomes evaluation of the screening application post-implementation in the pilot counties	(Estimated to take 6-8 months) Provide overall evaluation plan, evaluation results and recommendations based on completion of the following: 1. Evaluation kick-off meeting completed for requirement gathering 2. Evaluation plan delivered and approved 3. Evaluation completed 4. Evaluation report completed (including recommended revisions) Evaluation Team will deliver results from the following activities to both the CredibleMind and Help@Hand teams: a. 12-15 key informant interviews (e.g., clinicians, staff/management) b. 3-4 community focus groups (e.g., patients/families) c. County administrative/clinical records d. Patient data/records e. Patient in-take/surveys f. Documentary materials (e.g., project reports, meeting minutes)
19.1 Collaborate with the Evaluation Team to conduct process evaluation to establish a baseline evaluation and identify potential cost-effective and improvement areas via provider interviews and community member focus groups.	Evaluation Team will deliver results from the following activities to both the CredibleMind and Help@Hand teams: a. 8-10 key informant interviews from providers are more seasoned and work regularly with county screenings regularly from program/delivery level to administrative/executive level b. 2-4 community member focus groups (at least 1 in English and 1 in Spanish) to learn and understand patient/user experiences and perspectives Results will include a summary of current behavioral health system practices and delivery of mental health screenings in Monterey and LA Counties and will inform activities and objectives in 19.0 Evaluation.
19.2 Conduct an outcome evaluation of the application to assess efficiency and accuracy of referral connections, in collaboration with a cohort of County staff, community-based service providers, and other key informants	Provide outcome evaluation plan and outcome evaluation results and recommendations based on completion of the following: 1. Outcome evaluation kick-off meeting completed for requirement gathering 2. Outcome evaluation plan delivered and approved 3. Outcome evaluation completed 4. Outcome evaluation report completed (including recommended revisions)
19.3 Conduct an economic evaluation to assess the cost associated with self-assessments pre-post implementation of the mental health screening application and comparing cost of existing in-person screening to the	Provide an economic evaluation plan, economic evaluation results and recommendations based on the following: 1. Economic evaluation kick-off meeting completed for requirement gathering 2. Economic evaluation plan delivered and approved 3. Economic evaluation completed 4. Economic evaluation report completed (including recommended revisions)

virtual approach of the screening application	
19.4 Conduct general functionality and ease-of-use study through web analytics, web-based self-administered surveys, community focus groups and user testing with those using the application to determine usefulness of application for connecting targeted audience to resources	Provide a functionality and ease-of-use study plan, functionality and ease-of-use study results and recommendations based on the following: 1. Functionality and ease-of-use study kick-off meeting completed for requirement gathering 2. Functionality and ease-of-use study plan delivered and approved 3. Functionality and ease-of-use study completed 4. Functionality and ease-of-use study report completed (including recommended revisions)
19.5 Conduct impact evaluation of application with participating agencies/clinics as well as a cohort of community members	Provide impact evaluation plan, impact evaluation results and recommendations based on the following: 1. Impact evaluation kick-off meeting completed for requirement gathering 2. Impact evaluation plan delivered and approved 3. Impact evaluation completed 4. Impact evaluation report completed (including recommended revisions)
19.6 Work collaboratively with CalMHSA, Monterey and LA Counties to modify and refine the mental health screening application after input has been received	Provide refinement plan in collaboration with CalMHSA, Monterey and LA Counties based on completion of the following: 1. Refinement kick-off meeting completed for requirement gathering 2. Participation in and facilitation of refinement plan initiated 3. Participation in and facilitation of refinement plan initiated completed
19.7 OAC Report	Deliver final evaluation report meeting the following OAC requirements to CalMHSA and Counties no less than 6 months after previous deliverables Final evaluation results, including but not limited to: A. Description of the evaluation methodology B. Outcomes of the Innovative Project including those related to the selected primary purpose, with a focus on whatever was new or changed compared to established mental health practices C. Any variation in outcomes based on demographics of participants, if applicable D. Assessment of which activities or elements of the Innovative Project contributed to successful outcomes E. Explanation of how the evaluation was culturally competent F. Explanation of how stakeholders contributed to the evaluation. a. Whether and how the County will continue the Innovative Project, the source of ongoing funding, if applicable, the reason for the

	decision, and how the County involved stakeholders in the decision. b. Whether the Innovative Project achieved its intended outcomes and a summary of what was learned. c. Description of how the County disseminated the results of the Innovative Project to stakeholders, and if applicable to other counties (e.g. as the County determined that the information would be of benefit to other counties). d. Any other data or information the County considers relevant

For this Statement of Work, the following consumer/user data is the initial assumption of what will be provided by the vendor. Evaluation requirements may add additional data to be provided throughout the course of the project. Any additional data to be provided will be discussed with the Help@Hand team as the project progresses.

Data	Frequency
Demographic data such as age, gender, race, and ethnicity if provided	
Time it takes each user to complete the screening application	
Individual user responses from the screening application	
Responses leading to identification or severity, diagnosis, and referral	
Design validation study results for each county	Each round
Functionality and ease-of-use study data from web analytics, web-based self-administered surveys, focus groups and user testing - assess whether the screening application accurately gauges type and severity of mental illness - provides meaningful and accurate referral connections to the appropriate services or resources as efficiently as possible - determine whether the screening application reduces the hours and cost associated with in-person assessments - determine whether individuals (staff, community provider, peer, etc.) using this screening application to assist a user in need find the screening application useful for connecting that user to resources	
Impact evaluation - assess the overall impact the implementation of the screening application has on the total volume of patients entering services including its effects on the demographics of patients	

served	

CalMHSA Representatives:
Contract Representative: xxxx
Project Representative: xxxx

Appendix C: CredibleMind Research Plan

CredibleMind

October 2021

Help@Hand Screening Application Research Plan

1. Background

To inform the creation and development of the Help@Hand screening application, CredibleMind will conduct research into existing literature on mental health screening tools, engage with Monterey County staff and stakeholders, and map current resources and services in Monterey County Behavioral Health (MCBH) for at least seven proposed mental health conditions (outlined in 2. Goals).

As stated in the original request for proposal, "the primary problem being addressed by this project is the demand for mental health services outpacing the capacity of the mental health services system to appropriately screen and refer these individuals to treatment". In the case of MCBH, the demand for their gateway early intervention services, also known as ACCESS System of Care or simply ACCESS, has seen a 100% increase over a three-year period from FY2015-2017. The primary goal of this screening application is to reduce the burden on MCBH services.

This research plan provides an outline for the tasks and activities CredibleMind will undertake to fulfill research goals outlined in the statement of work. We recommend that this document be used to guide next steps, but may be subject to change depending on additional goals or questions that may surface throughout the research phase.

2. Goals

As stated in the statement of work, the goals for the research are as follows:

1. Document the evidence base on mental health screening tools and studies of self-assessment tools by age (16+) and language groups (English and Spanish)
2. Compare effectiveness of virtual tools with in-person or other approaches and their associated costs
3. Identify existing screening tools in English and Spanish for target mental health conditions
4. Identify the best practices for self-administered screening tools
5. Identify the best practices for validating a mental health screening tool or survey
6. Determine the perception of need from mental health and behavioral health agencies, the patients, and their personal support systems
7. Determine the barriers and facilitators to accessing mental health information, screening, referrals, and services
8. Determine perception and community preferences of using technology for mental health screening and access to services from providers, patients, and their family members/friends
9. Determine cost considerations for implementation of various types of virtual screening tools
10. Map the county behavioral health system through monitoring the county populations served and population trends, types of services offered, and key performance measures for behavioral health
11. Develop a final list of mental health conditions and other outcomes to include in screening application

Our initial research will focus on the following mental health conditions listed in the statement of work:

1. Anxiety disorders
2. Depression
3. Substance use disorders
4. PTSD
5. Bipolar disorder
6. Schizophrenia
7. Psychosis

Given that the majority of people who access MCBH services are MediCal recipients, or MediCal eligible, we will also consider including non-mental health condition outcomes such as social determinants of mental health (i.e. socioeconomic status, physical health, housing, transportation access and social support). There may be other mental health conditions that make sense to include for specific MCBH target audiences (i.e. ADHD for Transitional Age Youth populations).

3. Methodology

To better organize the research goals outlined above, there are three components to the research. Though each component will cover a specific set of goals, all three components will be informative in developing the final list of mental health conditions and outcomes (Goal 11).

A. Literature Reviews

A series of literature reviews will be conducted to assist with Goals 1-5. Here are the proposed steps for the "Review Component":

Step 1—Define the question.
Goals 1-5 can be further grouped into three main question themes:

a. *Evidence base on mental health screening tools and cost-effectiveness of virtual vs. in-person*
b. *Existing screening tools and best practices for self-administration for at least the 7 identified conditions as well as potential social determinants of health*
c. *Validation best practices and translation*

Step 2—Define the scope of review.
Scope includes: how many studies to review per question theme, how many years of studies to cover, age ranges and languages spoken by study population, studies with Medicaid/MediCal recipients, how many studies per condition/outcome

Step 3—Identify databases to search for literature.

Step 4—Conduct the review.

Step 5—Review and analyze the literature found.

Step 6—Synthesize and summarize findings for literature review reports.

B. Needs Assessment

A needs assessment will be conducted to assist with Goals 6-9. Depending on MCBH staff capacity and permission to survey current and/or former patients, we anticipate utilizing a mix of quantitative and qualitative methods such as interviews, focus groups, and surveys. Here are the proposed steps for the "Needs Assessment Component":

Step 1—Define the objectives and scope.

Including but not limited to experience with mental health screening, accessing services, finding information, the referral process, and technology preferences/accessibility

Step 2—Identify stakeholders/target populations.
May include H@H core team, ACCESS representatives, bilingual service providers, referral line operators, certain populations of potential users of the screening application (defining some typical user personas)

Step 3—Determine data collection methods.
Focus group and follow-up interviews/meetings with County professionals. Online and/or verbal questionnaires for clients and personal support systems

Step 4—Create prompts/script for interviewing and questionnaire.

Step 5—Schedule meetings and/or send questionnaires. Obtain informed consent and permission to record as needed.

Step 6—Conduct meetings and gather information. Record any verbal discussions.

Step 7—Synthesize and summarize findings for needs assessment report.

C. Behavioral Systems Mapping

Finally, we will conduct mapping of the resources and services within MCBH to assist with Goal 10. Here are the proposed steps for the "Mapping Component":

Step 1—Define scope of mapping.
Per SOW, will include information on general categories of populations served, most common mental health conditions, existing resources services, associated costs for accessing mental health services, and key behavioral health performance measures

Step 2—Identify sources for existing information.
May include co.monterey.ca.us web pages/documents, informational interviews with representatives from County departments, broader Help@Hand collected data, background information gathered while developing the RFP

Step 3—Conduct mapping.

Step 4—Synthesize, summarize, and visualize findings for mapping report.
Per SOW, we will encompass information for each screening application condition

4. Expected Results

At the conclusion of the research, we expect to deliver the following reports:

1. Results of literature review
2. List of screening tools for each condition/outcome
3. Results of needs assessment
4. Behavioral health system map of Monterey County including resources for each target condition/outcome

We also expect an early draft of questions for the screening application so we can begin testing the application internally in late 2021 or early 2022.

5. Timeline

The research will begin at the delivery of 2.0 Research Plan on October 12, 2021 and is expected to end at the delivery of 3.0 Conduct Research on February 3, 2022 for a span of about four months. Below is a detailed table of specific tasks and activities for each component and corresponding months.

Components	October 2021	November 2021	December 2021	January 2021	February 2021
Literature Reviews	Define research questions, scope of reviews Identify databases	Conduct review of literature Begin analysis of literature found	Continue analysis of literature	Continue analysis of literature Synthesize and summarize findings	Submit literature review reports
Needs Assessment	Define objectives and scope Identify stakeholders and target populations Determine data collection methods	Create prompts/scripts Schedule meetings and/or surveys	Conduct meetings and/or surveys Update prompts/scripts as necessary based on initial findings	Conduct meetings and/or surveys Synthesize and summarize findings	Submit needs assessment report
Behavioral Systems Mapping	Define objectives and scope Identify sources	Conduct mapping	Synthesize, summarize, and visualize findings	Submit systems mapping reports	

Appendix D: CredibleMind Research Report

CredibleMind

3.0 Research

MARCH 3, 2022

Introduction

The following pages include reports and required deliverables for 3.0 Conduct Research for the Help@Hand screening application project. Materials used to conduct the research tasks such as the environmental scan, literature review, needs assessment, and behavioral systems mapping are also included as appendices. All parts are listed in the Table of Contents below.

Table of Contents

Appendices (Not attached to this document)

A. Search terms and counts.pdf
B. Literature review comparison.xlsx
C. Clinical screening tools comparison chart.xlsx
D. Focus group and interview protocols.pdf
E. Copy of final survey.pdf
F. Informed consent letter.pdf
G. Slide deck for focus groups.pdf
H. Survey marketing materials.pdf
I. Copy of survey results.pdf
J. Copy of original systems mapping spreadsheet.pdf
K. Copy of systems mapping entry Google form.pdf

1. Description of Process

From November 2021 to December 2021, the CredibleMind Research team conducted an environmental scan using Google, Google Scholar, PubMed, and PsycINFO. Search criteria included articles that referenced "mental health"; "screening" or "scale" or "survey"; any of the six base conditions i.e. "depression" and "anxiety" as well as search criteria related to specific research goals such as "Spanish", "Hispanic", or "Latin*"; "virtual" or "online" or "electronic" or "internet"; and "evidence".[1] The environmental scan was guided by two research goals deriving from the project's statement of work for this deliverable.[2] There was an additional research goal that guided the scan deriving from Deliverable 3.1 List of Scales.

1. Research Goal 1: Document the evidence base on mental health screening tools and studies of self-assessment tools by age (16+) and language groups (English and Spanish)
2. Research Goal 2: Compare effectiveness of virtual tools with in-person or other approaches and their associated costs
3. Deliverable 3.1 Research Goal: Identify the best practices for self-administered screening tools with good psychometric properties that are available in English and Spanish for target conditions in ages 16 and up.

Section 2. Literature Review Summary in this document summarizes findings for Research Goals 1 and 2. For the additional research goal to *identify best practices for self-administered screening tools*, please see "Section 3: Review: Best Practices for Self-Administered Screening Tools" in Deliverable 3.1 List of Scales (pp. 10-20). References are listed on pp 40-53.

2. Literature Review Summary

Research Goal 1: Document the evidence base on mental health screening tools and studies of self-assessment tools by age (16+) and language groups (English and Spanish)

Evidence Base on Mental Health Screening Tools

The evidence base on the use of mental health screening tools to determine next steps for an individual seeking care has been well studied and documented for various mental health conditions. Next steps for an individual could involve various types of interventions or treatments ranging from self-guided web-based interventions for lower risk patients to referrals to trained mental health professionals who may conduct diagnostic interviews or assessments for moderate to higher risk patients (Whitton et al., 2021). Compared to psychiatric examinations, screening tools tend to be more efficient, take less time, are more cost-effective, and can be less invasive for the person who is being screened (Eaton et al., 2007; Newman, 2004).

Screening Tools and Youth Populations

Though screening tools have been generally beneficial in mental health care, there are reported differences in effectiveness of screening between adult and youth populations. As a whole, there is a need for strong

[1] See Appendix A: Search terms and counts
[2] See Appendix B: Literature review comparison

psychometric tools that measure disordered eating, suicidality, psychosis, and substance use in youth and adolescent populations (Becker-Haimes et al., 2020; Beidas et al., 2015). Many screening tools were originally created and validated in adult populations and when applied to youth populations, researchers tended to create "downward extensions" (Becker-Haimes et al., 2020, p. 10) instead of brand new scales and surveys for youth populations. Though some original adult scales have strong internal consistency in youth populations, such as the PHQ-9, it is important to consider using youth-specific scales and surveys whenever possible to ensure strong internal validity, reliability, and consistency with youth (Becker-Haimes et al., 2020). Youth tends to be a target population for many mental health resources and interventions, and, with strong screening tools, early identification and intervention practices can be implemented. Such practices have been shown to be associated with better outcomes later in life (Kline et al., 2015).

Types of Screening Tools: Self-Administered vs. Clinician-Administered

There are different ways screening tools can be administered. They can be self-administered with the user completing the tool either in their own time or in the presence of a clinician or they can be clinician-administered. There have been several studies documenting the evidence of self-administered tools compared to traditional clinician-administered methods of screening (Ballester et al., 2019; Richter & Johnson, 2005; Whitton et al., 2021). Self-administered tools have been found to be effective and in "reasonable concordance" (Ballester et al., 2019, p. 2) with clinician-administered assessments. There are many advantages to using self-administered tools over clinician-administered tools. Self-administered tools are "easy to administer to large samples" (Richter & Johnson, 2005, p. 810) and can be administered at the same time in different settings. They tend to be more cost-efficient since they do not take up clinician time—in many studies, self-administered tools are offered in waiting rooms in clinical settings and the clinician can quickly make an assessment based on screening tool results (Whitton et al., 2021).

Evidence Base of Self-Administered Tools

Self-administered tools are effective to screen for common mental health conditions like depression, anxiety (Ballester et al., 2019; Beidas et al., 2015), and substance use (Richter & Johnson, 2005). In youth populations, self-reported screening for psychosis is helpful to assess early psychosis onset, even six months later, as well as to develop treatments that are more specialized and psychosis-oriented (Kline et al., 2015).

There is also evidence to support the use of self-administered screening tools to increase widespread access to mental health resources. For college students, widespread self-administered screening was associated with increased uptake with mental health services and allowed for more students to get referred to mental health care and counseling (Forbes et al., 2019).

One disadvantage to self-administered tools compared to clinician-administered is the likelihood of false positives. For certain concerns like suicidality, self-administered measures are often associated with high false positive rates (Bryan & Rudd, 2006), possibly due to the sensitive nature of the topic. Despite false positive rates, when tools are coupled with appropriate interventions, they may still lead to cost savings and be effective in preventing symptoms from getting worse (Dunlap et al., 2019; Forbes et al., 2019).

Another disadvantage to self-administered tools is that the link between using a self-administered tool and change in treatment rates or help-seeking behavior is uncertain (Haberer et al., 2013). For clinician-administered screenings, individuals are usually able to receive treatment and services within the same sitting whereas, for self-administered, if the individual is not completing the tool in a clinical setting, then there may be barriers to going and accessing care and services if they screen positively for symptoms. Some

studies have pointed to an increase in individuals accessing care (Forbes et al., 2019; Whitton et al., 2021) as well as help-seeking behavior when self-administered tools are used(Mirea et al., 2021; Jacobson et al., 2022) while others have actually found that self-administered screening tools may lower the desire to seek help from professionals (Batterham et al., 2016). At the minimum, self-administered tools can provide information in an accessible way (Emmelkamp, 2005).

Self-administered tools may also be useful for individuals who have never been screened for any mental health symptoms. Whitton et al. (2021) developed a web-based screening tool to screen for anxiety and depression symptoms for patients to use while they wait in waiting rooms of primary care clinics. With this new screening method, they were able to discover an unmet need in that 1 out of every 16 people screened had unidentified or untreated symptoms of depression or anxiety (Whitton et al., 2021).

Mental Health Screening in Spanish-Speaking Populations

Within the last couple of decades, there have been many studies on screening tools and self-administered screening tools, specifically, that are beneficial to use in Spanish-speaking populations (Arrieta et al., 2017; Ballester et al., 2019; García-Campayo et al., 2012; Mills et al., 2014; Muñoz-Navarro et al., 2017). Many self-administered tools have been validated in a Spanish-speaking population for anxiety (García-Campayo et al., 2010; Mills et al., 2014; Muñoz-Navarro et al., 2017), depression (Arrieta et al., 2017; Killian et al., 2021), and bipolar disorder (Sanchez-Moreno et al., 2008; Vázquez et al., 2010).

In conclusion, there is strong evidence for the use of mental health screening tools and self-administered screening tools. Screening tools can screen a large number of individuals quickly and self-administered tools are more cost-effective compared to clinician-administered or psychiatric examinations. The main disadvantage to self-administered screening tools is the likelihood of false positives. In addition, it is unclear whether self-administered screening tools have a great impact on help-seeking behavior or treatment rates, but research in this area is promising. The use of self-administered tools is not meant to fully replace the need for in-depth assessments performed by a trained mental health professional, but they can be the first step to receiving mental health information and accessing care in a quick and efficient way.

Research Goal 2: Compare effectiveness of virtual tools with in-person or other approaches and their associated costs

Technology use in mental health care has increased over the past few decades (Marks, 1999). Strengths of using technology in mental health care include increased "accessibility, reduced costs…flexibility…inter-activity, and consumer engagement" (Lal & Adair, 2014, p. 26). Technology has been used to administer screenings instead of relying on paper-based tools and traditional in-person screening, which are often time-consuming (Lal & Adair, 2014). The advantages of virtual screening tools in particular have been well documented and include less social desirability bias (Buchanan, 2002; Marks, 1999; Richman et al., 1999), the ability to screen a large group of people quickly and efficiently (Ballester et al., 2019; Haberer et al., 2013; Newman, 2004; Wallace & Bendsten, 2014), cost-effectiveness (Emmelkamp, 2005), and reduced stigma (Emmelkamp, 2005).

Social desirability bias is a type of response bias in which people may answer questions in a survey or scale in a way that they will be viewed more favorably by others (Krumpal, 2013). It is an important bias to consider with screening and can be used to explain rates of underreporting or overreporting. Compared to being screened by a clinician, virtual screening may make it easier for individuals to disclose sensitive

information (Buchanan, 2002) and offer individuals the opportunity to be more candid when completing tests online (Richman et al. 1999), especially in regards to screening for alcohol and other substance use (Marks, 1999).

Underreporting in substance use screening is often an issue when using traditional screening methods (Marks, 1999; Gryczynski et al., 2017; Marsch et al., 2020) and individuals may feel more comfortable reporting risky behavior to a computer or electronic device rather than to an actual person (Marks, 1999). In a systematic review of digital health use for substance use disorders, Marsch et al. (2020) found that certain virtual screening tools have comparable diagnostic characteristics with clinician-administered versions. Gryczynski et al. (2017) found a similar comparison but noted that virtual self-administered tools resulted in higher rates of reporting of past year alcohol, illicit drug, and prescription medication misuse. High rates of positive screenings are likely to be associated with higher rates of false positives so users should be encouraged to seek out a professional to confirm any positive screenings (Donker et al., 2009).

Virtual screening tools allow for the potential to reach a wider audience. Traditional mental healthcare involves primarily face-to-face interactions between the clinician and patient. These interactions tend to be synchronous and may mean that mental health screenings occur on an "irregular and infrequent basis, [possibly] reducing the potential effectiveness" (Haberer et al., 2013, p. 349) of these screenings. Virtual screening can occur asynchronously which allows more flexibility for the individual to screen themselves regularly and frequently without having to wait for the next visit (Haberer et al., 2013).

Along with reporting the benefits of virtual screening tools for mental health, researchers have also determined that virtual tools are as effective in determining risk as traditional screening methods, such as paper-based and clinician-administered screening (Ballester et al., 2019; Brøndbo et al., 2013; Mirea et al., 2021; Riva et al., 2003; van Ballegooijen et al., 2016). Virtual screening tools have been found to be in "reasonable concordance" with clinician-administered assessments and screening (Ballester et al., 2019, p. 2). Brøndbo et al. (2013) found agreement in diagnostic categories for 3 out of 4 patients between a clinician assigning a diagnosis from the results of a virtual screening tool compared to regular clinician assessment without the use of a virtual tool.

Alfonsson et al. (2014) conducted a systematic review to investigate differences in interformat reliability between virtual and pen-and-paper versions of mental health screening tools for various conditions. They reviewed 33 publications and assessed interformat reliability for 40 different symptom scales and found that the majority of instruments showed strong correlation between format scores (Alfonsson et al., 2014). These 40 self-report instruments covered the following areas: panic disorder, depression, anxiety, eating disorders, alcohol and tobacco dependence or misuse, obsessive compulsive disorder, post-traumatic stress, postpartum depression, social anxiety disorder, and insomnia (Alfonsson et al., 2014).

Virtual screenings have also been found to be useful and effective in pregnancy and childbirth settings. Mental health issues are notoriously underdetected and undertreated in perinatal settings (Kingston et al., 2015; Kingston, Austin, et al., 2017), but virtual screening can help reduce stigma and empower individuals to seek care. In a randomized control trial, pregnant women who were randomized into an virtual screening (e-screening) group favored the features of e-screening more than the control group who completed the screening using a traditional paper-based method (Kingston, Austin, et al., 2017).

Though many researchers claim that virtual tools are cost-effective compared to traditional methods, these studies have not provided numbers on actual or estimated dollars saved. Sin et al. (2020) conducted a systematic review of web-based interventions that provided screenings and also came to a similar conclusion—data on cost-effectiveness is particularly lacking.

Most of the published literature claiming that virtual tools are cost-effective have been based on assumptions and not cost-benefit analyses. Although the initial costs of researching and developing virtual tools are necessary, ongoing costs are assumed to be minimal after development due to less time spent by a clinician to administer the screening or review paper-based screening (Lal & Adair, 2014). Another assumption is that virtual screening may reduce costs due to early intervention and prevention practices. De Gara et al. (2008) claimed that investing in early detection screening methods can result in future cost reductions and duration of symptoms and disease. They developed a model to compare direct and indirect costs related to psychological screening. Direct costs include time spent on screening by professionals while indirect costs may include lost work days, decreased productivity, and forgone earnings of the individual being screened (de Gara et al., 2008). Online screening could increase early detection of symptoms or an active mental health condition since it is more readily available and accessible than in-person screening.
Therefore, it's likely that being able to detect symptoms early before they worsen can help reduce therapy and treatment costs in the long-term (de Gara et al., 2008; Mirea et al., 2021). Early treatment can also influence indirect costs— undetected or untreated symptoms could worsen and affect a person's ability to work full-time or at all.

Despite the benefits of using virtual tools, there are many challenges facing successful implementation of virtual screening. As with any technology, privacy is a concern for many individuals and institutions (Haberer et al., 2013). Privacy measures have to be in place and tested to ensure that data is kept secure, even if the data is collected anonymously (Haberer et al., 2013). Another challenge is system and process changes within the current infrastructure. When converting screening from clinician-administered or paper-based to virtual, systematic changes need to be made to ensure efficient implementation. Current staff need to be trained and willing to adopt virtual screening into their current processes. Even if the tool is validated and shown to be effective, successful implementation is still dependent on widespread adoption (Haberer et al., 2013). Another challenge is limited access to certain groups. Although virtual tools may increase widespread access to mental health screening, there are still communities that will be left behind, as is the case with any technological innovation. Implementation may not be as successful for those living in remote or rural areas where internet access may be limited or for those who have limited proficiency in technology use, such as the elderly (Haberer et al., 2013).

Despite these challenges, the use of virtual tools for mental health screening is favorable as it can allow for " opportunities to improve access, quality, and sustainability of care for mentally challenged individuals in a system with limited resources" (Krausz et al., 2019, p. 139). More economic research is needed to determine estimated or actual cost savings for virtual screening tools compared to traditional methods.

3.1 List of Screening Tools

1. Description of Process

From November 2021 to December 2021, the CredibleMind Research team conducted an environmental scan using Google, Google Scholar, PubMed, and PsycINFO. Search criteria included articles that referenced "mental health"; "screening" or "scale" or "survey" or "measure*" or "assess*"; any of the six base conditions i.e. "depression" and "anxiety" as well as search criteria related to specific research goals such as "Spanish", "Hispanic", or "Latin*"; "virtual" or "online" or "electronic" or "internet"; and "self".[3]

From December 2021 to February 2022, members of our Clinical team were assigned to review scales based on their expertise and familiarity with the six baseline conditions. Anxiety and Depression scales were assigned to our clinical psychologist while Bipolar, Psychosis, Substance Use, and PTSD were assigned to our psychiatrists to review. The Clinical team was tasked to review each scale for its psychometric properties, study population, availability in Spanish, and other qualities.

In total, the Clinical team used fifteen qualities to compare scales within each condition category.[4] From this in-depth review, 17 scales were selected as candidates for use in the screening tool—this list is replicated below in Section 2: Recommended List of Screening Tools.[5] The recommended list of scales include scales that have strong psychometric properties (acceptable specificity, sensitivity, and Cronbach's alpha values), are brief (less than twenty questions), and have been validated in either a community setting or in a population that is generalizable to the screening tool's target population. Almost all of the scales are available in Spanish and have been validated in a Spanish-speaking population. Many of these have been administered as self-report or electronically.

For the purposes of the deliverable, the Research and Clinical teams have determined that the list of scales below are ideal to meet the needs of the research goals. Further discussions with the County will be necessary to determine the best scale (or two scales for two-stage screening) for each condition, County needs, and overall project goals.

2. Recommended List of Screening Tools

The CredibleMind Clinical team, along with the Research team, present the following list of evidence-based clinical assessment and screening tools for outcomes of interest in English and Spanish:

Scale name *(Citations)*	**Condition(s) screened**	**# of items**	**Team notes**
4-item Patient Health Questionnaire (PHQ-4)	Anxiety Depression	4	We can ask remaining questions in the GAD-7 (for

[3] See Appendix A: Search terms and counts
[4] See Appendix C: Clinical screening tools comparison chart spreadsheet

[5]Table lists 15 scales and does not include separate rows for the GAD-7 or PHQ-9

(English: Kroenke et al., 2009) (Spanish for the USA GAD-7) (Spanish for the USA PHQ-9)			anxiety) or PHQ-9 (for depression) questions upon positive screening.
Washington Early Recognition Center Affectivity and Psychosis (WERCAP) *(English: Mamah, 2011) **No Spanish version found***	Bipolar Disorder Psychosis	16: 8 per condition	Ideal scale for Psychosis For Bipolar, we can start with WERCAP, then go onto BSDS or MDQ. For Bipolar, WERCAP is not as ideal as BSDS because questions read too extreme and may miss those with low manic states.
Bipolar Spectrum Diagnostic Scale (BSDS) *(English: Ghaemi et al., 2005) (Spanish: Vázquez et al., 2010)*	Bipolar Disorder	1-question story, then 18	Two-stage screener that begins with a story. If story resonates with user, then they can move onto the rest of the scale
Mood Disorders Questionnaire (MDQ) *(English: Hirschfield et al., 2000) (Spanish: Sanchez-Moreno et al., 2008)*	Bipolar Disorder	18	Has a parent version (P-MDQ) and adolescent version (A-MDQ)
Community Assessment of Psychic Experience (CAPE) *(English: Konings et al., 2006) (Spanish: Ros-Morente et al., 2011)*	Psychosis	15	Can use the shorter version (CAPE-15)
Self-screen-Prodrome (SPro) *(English: Kammerman et al., 2009) **No Spanish version found***	Psychosis	6	Not meant to be diagnostic so ideal for this project
Prodromal Questionnaire (PQ-16) *(English: Ising et al., 2012) (Spanish: Levey et al., 2018)*	Psychosis	16	Can help pick up on early symptoms as opposed to DSM diagnosis qualifiers only.
Primary Care PTSD screen (PC-PTSD-5) *(English: Prins et al., 2016) (Spanish PC-PTSD-5)*	PTSD	5	Two-stage screening model per VA standards. For the second stage, move onto PCL-5.
PTSD Checklist for DSM-V (PCL-5) *(English: Blevins et al., 2015) (Spanish PCL-C: Orlando & Marshall, 2002) (Spanish PCL-5)*	PTSD	20	The PCL-5 is the DSM-V version whereas the PCL-C is the DSM-IV version.

SBIRT pre-screen *English version* *Spanish version*	Substance Use	3	Standard two-stage model. For the second stage, move onto ASSIST, TAPS, or for specific substances,

			DAST-10 (drugs only) or USAUDIT-c (alcohol only)
Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) *(English: Group, 2002) (Spanish: Rubio Valladolid et al., 2014)*	Substance Use	1, then 7	Interview format that can be converted to a one question screener. Upon a positive screen, the user can move onto the remaining questions.
Tobacco, Alcohol, Prescription Drug, and Illicit Substance Use (TAPS) *(English: Wu et al., 2016) (Spanish: Sanchez et al., 2021)*	Substance Use	4, then 9	Two-stage screener with first four questions as the first stage. Upon a positive screen, the user can move on to the remaining questions.
10-item Drug Abuse Screening Test (DAST-10) *(English: Skinner, 1982) (Spanish: Bedregal et al., 2006)*	Substance Use (Drugs)	10	
USAUDIT-c *(English: Higgins-Biddle & Babor, 2018) (Spanish version)*	Substance Use (Alcohol)	3, then 7	Two-stage screener with first three questions as the first stage. Upon a positive screen, the user can move on to the remaining questions.
CRAFFT (Car, Relax, Alone, Forget, Friends, Trouble) Screening Instrument *(English: Knight et al., 1999) (Spanish version)*	Substance Use (Adolescents)	4, then 5	Recommend this separate screening for adolescents. Any substance use is considered high risk in terms of functional outcomes. There is a CRAFFT 2.1 and 2.1+N which also measures tobacco and nicotine use.

3. Review: Best Practices for Self-Administered Screening Tools

The second half of this deliverable was to identify the best practices for self-administered screening tools with good psychometric properties that are available in English and Spanish for target conditions in ages 16 and up. From November 2021 to December 2021, the CredibleMind Research team conducted an environmental scan using Google, Google Scholar, PubMed, and PsycINFO.[6,7] References are listed on pp 40-53.

[6] See Appendix A: Search terms and counts
[7] See Appendix B: Literature review comparison

Research Goal: Identify the best practices for self-administered screening tools with good psychometric properties that are available in English and Spanish for target conditions in ages 16 and up

Anxiety

Anxiety is one of the most commonly screened mental health conditions (Ballester et al., 2019; Beidas et al., 2015) and several tools have been developed to screen for anxiety symptoms. In 2011, Pilkonis et al. reported 145 different scales that measure anxiety. Anxiety measures used today tend to fall into two categories: generalized tools which measure common characteristics of various anxiety disorders and situation-specific tools which measure anxiety in response to specific events such as test anxiety, computer anxiety, or cancer anxiety (Rose & Devine, 2014).

To determine best practices for self-administered screening tools for anxiety, one of the main considerations to take into account is the target population. Generalized tools work well for larger sample sizes (Rose & Devine, 2014). Another consideration is content of interest (Rose & Devine, 2014). Since this tool is meant to be used for screening and not for diagnostic purposes, brief measures that screen for general anxiety and not specific types of anxiety such as agoraphobia are ideal. The Generalized Anxiety Disorder scale (GAD-7) (Spitzer et al., 2006) is an ideal scale to use in community or primary care settings—it is brief, can be self-administered, and has been used in virtual settings (García-Campayo et al., 2010; Plummer et al., 2016). The GAD-2 (Kroenke et al., 2007), the shorter version of the GAD-7, has also been found to be acceptable to use for identifying generalized anxiety symptoms (Plummer et al., 2016).

Anxiety in Spanish-speaking populations

The GAD-7 was originally translated and validated in Spanish with individuals seeking care and treatment for mental health conditions in Spain, half of which had a prior diagnosis of clinical generalized disorder anxiety and half of which did not (García-Campayo et al., 2010). Members of the same group of researchers also later validated the GAD-2 in primary care clinics in Spain (García-Campayo et al., 2012). The GAD-7 has since been validated in a group of Hispanic Americans with English or Spanish language preference recruited from a community sample (Mills et al., 2014). A computerized version of the GAD-7 has also been validated in primary care centers in Spain but researchers note high false-positive rates as a limitation (Muñoz-Navarro et al., 2017). They suggest other measures should be conducted to confirm a positive GAD-7 screening such as using a depression measure to determine the presence of generalized anxiety with comorbidities and/or having a clinician perform a clinical interview to confirm (Muñoz-Navarro et al., 2017).

Interestingly, Mills et al. (2014) found that the "Spanish language-preference group had higher GAD-7 total scores and greater variability in scores in comparison to the English language-preference group" (p. 7). However, after controlling for socioeconomic and demographic factors, they found no significant differences in GAD-7 scores between the language-preference groups (Mills et al., 2014). Despite the lack of statistical significance, it is still important to consider socioeconomic differences when measuring anxiety in Spanish language-preference groups. The immigrant experiences of Spanish language-preference groups are vastly different and may result in varying levels of worry and distress which could help explain the varying GAD-7 scores found between language-preference groups (Mills et al., 2014).

Depression

Depression is another of the most commonly screened mental health conditions (Ballester et al., 2019; Beidas et al., 2015) and has become a priority for screening in primary care settings due to high rates of

undetected cases (Houston et al., 2001). In 2009, the US Preventive Services Task Force released a recommendation statement to screen all adults when "staff-assisted depression care supports are in place and selective screening based on professional judgment and patient preferences when such support is not available" (Siu et al., 2016, p. 386). They updated this recommendation statement in 2016 to remove selective screening after recognizing these supports are "much more widely available and accepted as part of mental health care" (Siu et al., 2016, p. 386). In the 2016 update, they also recommend depression screening specifically in perinatal settings given the impact depression can have on the health and wellbeing of not only the pregnant person or new parent, but also their child (Siu et al., 2016).

Best practices for using self-administered screening tools for depression depend on the target population. The 9-item Patient Health Questionnaire (PHQ-9) (Kroenke et al., 2001) is a self-report tool that is brief and has been used widely (Reynolds & Patel, 2017). In general settings, it is recommended to also screen for anxiety because depression and anxiety frequently co-exist (Reynolds & Patel, 2017). For all populations, it is recommended to provide psychoeducation or access to therapy or counseling, especially when screening virtually (Buchanan, 2002). Mirea et al. (2021) found that including online psychoeducation with comprehensive mental health screening for individuals experiencing depression symptoms had a positive effect on the mental health of individuals searching for mental health information—65% of 1300 participants rated the psychoeducation component as useful. The implications of adding psychoeducation and therapy options to virtual screening results will be discussed in more detail in a later section.

The PHQ-2 (Kroenke et al., 2003), the shorter version of the PHQ-9, has been found to be a useful screening tool in many studies (Arroll et al., 2010; ; Levis et al., 2020; Manea et al., 2016). Many researchers recommend using a cut-off score of 2 or more rather than 3 or more to ensure that potential diagnoses are not missed (Arroll et al., 2010; Manea et al., 2016). However, a lower cut-off score is associated with lower specificity, resulting in the potential of higher false positive rates (Manea et al., 2016). For youth populations, some researchers found that a cut-off of 3 or more was ideal for maximizing sensitivity without a significant loss in specificity (Richardson et al., 2010) while others used a cut-off of 2 or more but still found the PHQ-9 to be superior in screening for depression in an adolescent population (Anand et al., 2021). To ensure accurate and quick screening, it is recommended to use the PHQ-2 followed by the PHQ-9 (Levis et a., 2020).

For perinatal populations, the detection and treatment of postpartum depression remains a high priority (Drake et al., 2014; Kingston et al., 2015; Kingston, Austin, et al., 2017). There is a lot of stigma associated with postpartum depression so many individuals may report very few or no symptoms to clinicians during screening (Kingston, Biringer, et al., 2017). Virtual methods of screening have been useful in providing an easy and more accessible way of being screened and destigmatizing discussing and seeking care for postpartum depression (Drake et al., 2014; Kingston, Austin, et al., 2017). One study that used technology to administer the Edinburgh Postnatal Depression Scale (EPDS) found this method to be reliable, valid, and in alignment with paper-based screening methods (Drake et al., 2014). Participants in another study reported the features of virtual screening more favorably than paper-based and preferred using a device to answer questions rather than paper-based (Kingston, Austin, et al., 2017).

Depression in Spanish-speaking populations

The PHQ-9 has been shown to be a valid measure for Latinx populations in the US for both English and Spanish-language preference groups (Huang et al., 2006). The PHQ-2 has also shown to be valid for use in Spanish-speaking populations (Arrieta et al., 2017). Despite strong validity, some researchers have reported poor internal reliability for the PHQ-9 for Latinx populations, especially for female-identifying groups. Killian

et al. (2021) found that "the single item related to fatigue had the greatest variation" (p. 8) across all race/ethnicity profiles. Particularly for the Latinx population, moderate symptoms could be categorized into two profiles: those with higher scores on questions related to somatization symptoms—feeling tired, having little energy, or sleeping too much and those with higher scores on questions related to negative self-view—feeling down or feeling bad about yourself (Killian et al., 2021). They recommend a follow-up clinical assessment be conducted "to tease out the burden of symptoms and personalize treatment accordingly" (Killian et al., 2021, p.9).

Bipolar disorder

Bipolar disorder is known to be underdetected in primary care settings (Carvalho et al., 2015; Zimmerman et al., 2011; Zimmerman, 2014). Several screening tools have been created to help increase routine screening for bipolar in primary care settings (Carvalho et al., 2014; Zimmerman et al., 2011) but many clinicians have encountered high false positive rates and misdiagnoses when using screening tools alone to detect bipolar disorder symptoms (Zimmerman, 2014).

Bipolar disorder symptoms are characterized by extreme highs (mania or hypomania) and lows (depression). Individuals with bipolar disorder are also more likely to experience symptoms of depression and anxiety; therefore, the overlap of depression symptoms plus higher likelihood of comorbidities have resulted in bipolar disorder being underdiagnosed often or misdiagnosed anxiety or depression disorders (Zimmerman, 2014)

The Bipolar Spectrum Diagnostic Scale (BSDS) (Nassir Ghaemi et al., 2005) and Mood Disorders Questionnaire (MDQ) (Hirschfield et al., 2000) are examples of bipolar self-administered screening tools that have been used in primary care settings. Carvalho et al. (2015) conducted a systematic review and meta-analysis of accuracy studies for bipolar screening and assessment tools including the BSDS and MDQ. They found that there were more studies supporting accuracy properties for the MDQ than the BSDS (Carvalho et al., 2015). BSDS had high sensitivity and specificity rates at a cut-off score of 12 in a population of individuals with major depressive disorder or bipolar disorder (Zimmerman, 2014). However, for the detection of bipolar II disorder, the MDQ is less satisfactory because of its poor specificity and high possibility of false positive rates (Zimmerman et al., 2011), possibly due to the potential for individuals to misrepresent or misremember hypomanic episodes and symptoms (Carvalho et al., 2015). Researchers recommend combining any positive screening with a follow-up assessment to confirm diagnostic criteria.

In younger populations, two versions of the MDQ were introduced by Wagner et al. (2016): a parent-version (P-MDQ) and an adolescent-version (A-MDQ). Youngstrom et al. (2005) conducted a study comparing the validity of screening for bipolar disorder between parent and adolescent versions of the MDQ and found the P-MDQ acceptable to use but not the A-MDQ. However, Miguez et al., (2013) found the A-MDQ to be acceptable for screening but because of high false positive rates, they recommend a follow-up assessment to confirm a positive screening.

The Washington Early Recognition Center Affectivity and Psychosis scale (WERCAP) (Mamah, 2011) was developed to detect both bipolar disorder and psychosis symptoms and has been validated in a youth sample (Mamah et al., 2014). Though some researchers have not found the WERCAP as useful to detect bipolar disorder symptoms due to the heterogeneity of symptoms and potential for confounders (Mamah et al., 2014), others have shown that the bipolar disorder section of the WERCAP had high sensitivity and specificity rates at an optimal cut-off score of more than 20 (Hsieh et al., 2016).

Another consideration to take into account when screening for bipolar disorder is that because borderline personality disorder (BPD) and bipolar disorder share similar symptoms, BPD is often misdiagnosed as bipolar disorder (Zimmerman et al., 2010). Especially when using the MDQ for screening, Zimmerman et al. (2010) found that BPD was four times more frequently diagnosed in positive MDQ screenings than negative MDQ screenings. Palmer et al. (2021) found that certain items in the MDQ were significant predictors of bipolar disorder and non-predictors of BPD so upon a positive screen, they suggest looking these particular items more closely.

For self-administered bipolar disorder screening, the best practice is to follow-up with a clinical diagnostic assessment or interview to confirm a positive screen as well as to rule out other mental health conditions such as borderline personality disorder.

Bipolar disorder in Spanish-speaking populations

The BSDS and MDQ have been translated and validated in Spanish-speaking populations (Sanchez-Moreno et al., 2008; Vázquez et al., 2010). When validating the Spanish version of the BSDS within a sample of psychiatry patients in the US, Vázquez et al. (2010) found that lowering the cut-off score from 13 to 12 increased the scale's sensitivity and slightly decreased the specificity. Sánchez de la Cruz et al. (2018) also found that a cut-off score of 12 was the most ideal for sensitivity and specificity within a sample of psychiatry patients in Mexico.

When validating the MDQ within a sample of psychiatry patients in Spain, Sanchez-Moreno et al. (2008) found a cut-off score of 7 or more hypomania symptoms showed the best balance of sensitivity and specificity for detecting bipolar disorder.

To date, the WERCAP has not been translated into Spanish or validated within a Spanish-speaking population, but it has been successfully translated into Kamba and validated within a community sample in Kenya (Ndetei et al., 2019)—therefore, successful translation, cross-cultural adaptation, and validation into other languages and non-English-speaking populations is promising.

Psychosis

Psychosis has typically been screened using clinician-administered tools or interview settings which can be time-intensive and difficult to scale in community settings (Addington et al., 2015; Kline & Schiffman, 2014). Kline & Schiffman (2014) conducted a systematic review and found 13 self-report measures used to identify "individuals at clinical high risk of psychosis" (p. 12) including the Community Assessment of Psychic Experiences (CAPE) (Konings et al., 2006) and the 16-item Prodromal Questionnaire (PQ-16) (Ising et al., 2012). They found a wide range of psychometric data based on study settings (Kline & Schiffman, 2014).

In an adolescent sample, Mossaheb et al. (2012) reported that a cut-off score of 3.2 for the CAPE had moderate sensitivity and specificity and lowering the cut-off to 2.8 increased the sensitivity but decreased the specificity and had higher rates of false positives. For the PQ-16, a cut-off score of 6 or more demonstrated good sensitivity and specificity values and lower rates of false positives (Ising et al., 2012). McDonald et al. (2019) studied the performance of an web-based version of the PQ-16 in the general population and also found that a cut-off score of 6 or more demonstrated good sensitivity and specificity values.

As mentioned in the **Bipolar disorder** section, the WERCAP can also be used for psychosis screening (Mamah, 2011). The WERCAP was found to perform well for psychosis screening, especially for estimating "overall psychosis severity" (Mamah et al., 2014, p. 1766). In a large longitudinal population-based study of adolescents and young adults, the WERCAP was also validated for psychosis screening with 3-month timeframes being the most predictive of meeting diagnostic criteria for psychosis (Mamah et al., 2022).

The Self-screen-Prodrome (SPro) (Kammerman et al., 2009) is another self-report psychosis screening that has been validated for use in the general population as a first step in an assessment or diagnostic process (Müller et al., 2010) as well as to distinguish symptoms between ADHD and psychosis (Corbisiero et al., 2017). In a systematic review, Addington et al. (2015) found that using a 6-item subscale, also known as SPro-Psy-Risk, was acceptable to distinguish between positive psychosis screenings from other psychiatric diagnoses.

For self-administered psychosis screening, the best practice is to follow-up with a clinical diagnostic assessment to confirm positive screenings. If possible, it is also recommended to ask individuals to answer questions with shorter time frames in mind, such as 3-months (Mamah et al., 2022).

Psychosis in Spanish-speaking populations

There is a literature gap regarding mental health service use for psychosis among Latinx populations—from what is available, researchers estimate low usage rates and low treatment rates (Casas et al., 2014). Low usage may derive from low screening rates or underdiagnosis of psychosis in Latinx communities (Mischoulon et al., 2005). Underdiagnosis may be prevalent among Spanish-speakers due to the low level of psychosis literacy (Casas et al., 2014) and differing manifestations of psychosis symptoms (Mischoulon et al., 2005). In a large epidemiological study that looked at racial and ethnic differences in the prevalence of psychosis symptoms, higher lifetime rates of psychosis symptoms were reported by Latinx than any other racial or ethnic group (Cohen & Marino, 2013). Despite higher prevalence of psychosis symptoms, only a small percentage of Latinx individuals meet diagnostic criteria for a psychosis disorder (Lewis-Fernández et al., 2009).

Routine psychosis screening in community settings is a high priority due to the association between risk of psychosis and risk of lifetime health condition or disability (Oh et al., 2018; Oh et al., 2019). In one study, Oh et al. (2019) found that the odds of reporting a lifetime health condition or disability was 1.75 times greater for those experiencing psychosis symptoms. In a previous study, Oh et al. (2018) found that the odds of reporting lifetime experiences of psychosis symptoms was about 1.5 to 3 times greater for individuals with disabilities. However, these epidemiological surveys grouped Black, Asian, and Latinx individuals together, so the literature gap on implications for psychosis screening in Latinx communities still persists.

Some scales have been translated into Spanish but limited validation studies in the general population or community settings exist. The Spanish version of the CAPE was found to have good consistency with the English version (Ros-Morente et al., 2011), but the only validation study to date was conducted among college students at a university in Spain (Fonseca-Pedrero et al., 2012). The PQ-16 has been translated into Spanish and validated for use within a pregnant population in Peru (Levey et al., 2018).

Neither the SPro nor the WERCAP has been translated into Spanish or validated within a Spanish-speaking population.

PTSD and Trauma

PTSD is also a commonly screened mental health condition (Lancaster et al., 2016). Screening for PTSD in a non-military, general population has become more widespread and several tools exist to allow for a quick identification of those at risk for PTSD based on their "exposure to a Criterion A traumatic event" (Lancaster et al., 2016, p. 3). In the DSM-V, Criterion A traumatic events include "actual or threatened death, serious injury, or sexual violence" (American Psychatric Association, 2013, pp. 271-272). On a higher level, exposure includes directly experiencing the event, witnessing it in-person, learning that the event happened to a close family member or friend, or experiencing repeated or extreme exposure to details of the event secondhand i.e. in the case of first responders (American Psychiatric Association, 2013). Trauma screening tools work well in busy settings such as primary care clinics (Lancaster et al., 2016). The Life Events Checklist is an example of a trauma-exposure screener that has been supported for use in the literature (Gray et al., 2004). There is now a DSM-V version, the LEC-5 (Weathers et al., 2013).

Trauma screening tools are often combined with PTSD symptom screeners (Lancaster et al., 2016). Both the Primary Care PTSD Screen (PC-PTSD) (Prins et al., 2004) and PTSD Checklist-Civilian Version (PCL-C) (Blanchard et al., 1996) are used widely to screen for PTSD (Freedy et al., 2010; Lancaster et al., 2016). In a study comparing several PTSD screening tools, Freedy et al. (2010) found that both the PC-PTSD and PCL-C performed well and showed adequate sensitivity and specificity—they preferred the PC-PTSD for its briefness.

The US Department of Veteran Affairs (n.d.) recommends a two-stage screening process for PTSD that begins with the PC-PTSD-5 (Prins et al., 2016), the DSM-V version of the PC-PTSD. For the second stage, they recommend a structured interview but also suggest using a validated self-report measure if an interview is not possible. Specifically, the PCL-5 (Blevins et al., 2015), the DSM-V version of the PCL-C, was mentioned as having strong psychometric properties (US Department of Veteran Affairs, n.d.). This two-stage screening process of using the PC-PTSD-5 first and then the PCL-5 has also been found to be acceptable for use in youth populations (Nadeem et al., 2021).

PTSD and Trauma in Spanish-speaking populations

There are many historical, cultural, and social considerations that need to be taken into account when screening for PTSD and Trauma in Latinx populations. These include immigration status, country of origin, current family structure, current community connection, spirituality and religion, and language (Fierros & Smith, 2006; Fortuna, n.d.). There are also certain terms that some Spanish-speakers use to describe feelings of distress. Also known as "culture-bound syndromes" (Fortuna, n.d, p.3), knowing and including these terms in screening tools or clinical assessments may help contextualize certain symptoms. For example, *ataque de nervios* is often brought up as a symptom or experience in Latinx populations and includes "uncontrollable screaming or shouting, crying, trembling, sensations of heat rising in the chest and head, dissociative experiences, and verbal or physical aggression" (Fortuna, n.d., p. 3).

The PC-PTSD-5 has been translated into Spanish but it is unknown who did the original translation and it is also unclear whether this version has been validated. A virtual version of the DSM-IV PC-PTSD worked well among Spanish-speakers in a community health center (Ahmad, 2017).

The DSM-IV version of the PCL-C has been translated into Spanish but the original translation study did not find the Spanish version fully equivalent to the English version based on differential item functioning parameters (Orlando & Marshall, 2002). Despite the lack of full equivalency, Orlando & Marshall (2002) still

find it acceptable to use for general screening. Miles et al. (2008) revealed that the inconsistent equivalency discovered in the original Orlando & Marshall (2002) study was not significant, deeming the two versions equivalent (Miles et al., 2008). The Spanish PCL-C has since been validated within a pregnant population in Peru (Gelaye et al., 2017). The PCL-5 has been translated into Spanish. It is uncertain who did the translation or if the translated version has been validated, but the Spanish PCL-5 has been used in at least three studies (Carmona Camacho et al., 2021; Sangrà, et al., 2021; Sobregrau Sangrà et al., 2022).

Substance use

For substance use screening, the SBIRT or Screening, Brief Intervention, and Referral to Treatment model is a validated, comprehensive public health approach that has been implemented in a variety of settings (SAMHSA, n.d.). Self-administered and virtual screening methods have been found to work well for measuring substance use—since substance use is heavily stigmatized, users may feel more comfortable disclosing substance use via self-administered or virtual options (McNeeley et al., 2018; Richter & Johnson, 2001; Wallace & Bendsten, 2014). Therefore virtual screening can be a useful approach during implementation of the first step of the SBIRT model.

One thing to consider when using virtual tools for substance use screening is to have a clear statement for participants that their information and data will be kept confidential (McNeely et al., 2018; Wallace & Bendsten, 2014). Alcohol use especially tends to be underreported in traditional screening methods, possibly due to social desirability bias (Richter & Johnson, 2001) or stigma and perceived consequences of disclosing substance use (McNeeley et al., 2018).

Similar to PTSD screening, substance use screening also follows a two-stage model. In the first stage, a scale or one-question pre-screener is completed to determine which substance(s) might be at risk of misuse, if any (Saitz et al., 2014). For the second stage, specific questions about the substances are primarily asked in the context of dependence, risk, or if there have been any health, social, legal, or financial problems as a result of substance use. Examples of second-stage screeners include the Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) (Group, 2002), the Tobacco, Alcohol, Prescription Drug, and Illicit Substance Use (TAPS) tool (Wu et al., 2016), the 10-item Drug Abuse Screening Test (DAST-10) (Skinner, 1982), the Alcohol Use Disorders Identification Test (AUDIT) (Saunders et al., 1993), and for youth populations, the CRAFFT screening instrument (Knight et al., 1999).

The ASSIST 2.0, the briefer version of the ASSIST, is clinician-administered and acceptable to use in primary care settings—it measures 10 substances: tobacco, alcohol, cannabis, cocaine, amphetamine-type stimulants (ATS), inhalants, sedatives, hallucinogens, opioids, and 'other drugs' (Group, 2002). A validation study determined that the ASSIST is able to "discriminate between low, moderate, and high risk substance use…[especially] for alcohol, cannabis, ATS, opioid, and cocaine use" (Humeniuk et al., 2008, p. 7). The ASSISTc, a computer-based version of the ASSIST, has been validated in a sample of university students in Brazil and found to be comparable to the interview version (Christoff et al., 2016). Barreto et al. (2014) adapted the ASSIST to use as a self-administered version and validated it in a sample of university students in Brazil. They found this version to be acceptable for use and comparable to the interview version though correlation scores between the self-administered version and interview version for cocaine, ATS, sedatives, inhalants, and hallucinogens were poor (Barreto et al., 2014).

The TAPS tool is a two-stage screening and brief assessment tool and measures all commonly used substances (Wu et al., 2016). As a response to the ASSIST, it was developed to take less time and is validated

for self-administration (Wu et al., 2016). The first stage, the TAPS-1, is used for screening and asks about frequency of use of tobacco, alcohol, illicit drugs, and nonmedical use of prescription medications (Wu et al., 2016). The second stage, the TAPS-2, further assesses the use of positively screened substances and also provides a risk level (Wu et al., 2016). The TAPS tool has been shown to be acceptable to use via self-administered and virtual screening approaches and the TAPS-1 can be administered as a standalone screener (Adam et al., 2019; McNeely et al., 2016; Wu et al., 2016). One thing to note in a study that used virtual TAPS screening is that the addition of audio guidance proved to be an important feature (Adam et al., 2019). Adam et al. (2019) found that 18% of participants used audio guidance—those who used this feature were more likely to have lower education, be older than 65, and were either Latinx or Black. Therefore if an audio option is not feasible, researchers recommend some variation of interview-administration to ensure the tool is accessible for as many people as possible (Adam et al., 2019).

The DAST-10 screens for drug use only and has been validated for use in a variety of populations and settings (Yudko et al., 2007). It has also been validated for use as a self-administered tool in primary care settings (McNeeley et al., 2021) and has been used for virtual screening (Talih et al., 2018). However, some studies have reported that a one-question screener is as effective at identifying drug misuse as the DAST-10 (Hearon et al., 2015; Smith et al., 2010).

The USAUDIT-c screens for alcohol use only and is a more accurate version of the AUDIT because of its briefer screening capability and adaptation to standard drink sizes found in the US (Higgins-Biddle & Babor, 2018). The USAUDIT-c is a two-stage screener where users are asked three questions about their alcohol consumption and upon positive screening, are asked an additional seven. It has been validated for use as a self-administered tool in primary care settings (McNeeley et al., 2021) and as a virtual tool to screen for at-risk drinking (Villarosa-Hurlocker et al., 2020).

The CRAFFT screening tool was developed specifically to screen for substance use among adolescents and stands for: Car, Relax, Alone, Forget, Family/Friends, and Trouble (Knight et al., 1999). There is an interview version and a self-administered version and the self-administered version is preferred (Boston's Children Hospital, n.d.). A virtual self-administered version of the CRAFFT has been validated for use in primary care settings (Harris et al., 2016). Some researchers suggest altering the yes/no binary response format to assess for frequency of use to improve sensitivity as yes/no questions tend to have a greater likelihood of underreporting (Harris et al., 2016). Others suggest modifying the Car item to account for groups that may be less likely to be in cars in order to reduce disparities in sensitivity rates among different racial ethnic groups and socioeconomic statuses (Lee et al., 2021). There are two additional versions of the CRAFFT: the CRAFFT 2.1 has higher sensitivity than its predecessor and also includes vaping and the CRAFFT 2.1+N has extra questions related to tobacco and nicotine use (Boston Children's Hospital, n.d.).

Substance use in Spanish-speaking populations

Many substance use screening tools have been translated into Spanish and validated within Spanish-speaking populations (Bedregal et al., 2006; García Carretero et al., 2016; Pérez Gómez & Díaz-Granados, 2011; Rubio Valladolid et al., 2014; Sanchez et al., 2021).

The Spanish version of the ASSIST has been validated in primary care settings and specialized addiction treatment centers in Spain (Rubio Valladolid et al., 2014). Lopez-Rodriguez & Rubio Valladolid (2018) validated a virtual version of the ASSIST that was accessed online and available to the general public. They found this method worked well for estimating prevalence of at-risk substance misuse (Lopez-Rodriguez & Rubio Valladolid, 2018). McNeely et al. (2014) converted the ASSIST into an audio guided computer assisted self interview format and found it to be feasible and acceptable to use in Latinx populations.

The TAPS tool has been translated and found to be feasible to use within a Latinx sample in a US-based primary care setting (Sanchez et al., 2021) but has not yet been validated. The DAST-10 has been translated and validated within a Latinx population in the US (Bedregal et al., 2006). Researchers reported using a cut-off score of 4 to identify drug misuse had stable psychometric properties (Bedregal et al., 2006).

The original AUDIT has been translated into Spanish and validated within a sample in Spain (Contel et al., 1999). THe AUDIT-C, which are the first three questions of the AUDIT, has been translated into Spanish and validated within a university setting in Spain (García Carretero et al., 2016). The USAUDIT-c has been translated into Spanish but has not yet been validated.

The CRAFFT has been translated into Spanish and validated within a sample of adolescents in Colombia (Pérez Gómez & Díaz-Granados, 2011), Argentina (Bertini et al., 2015), and Spain (Rial et al., 2019). In all three settings, the CRAFFT had adequate to strong psychometric properties and was shown to be acceptable for use in screening adolescents for substance use. The CRAFFT has been validated for use in Latinx populations in the US, but studies were done in English using the English version (Lee et al., 2021). Both the CRAFFT 2.1 and CRAFFT 2.1+N have been translated into Spanish (Boston Children's Hospital, n.d.).

Suicidality considerations

In the PHQ-9, item 9 reflects suicidality and thoughts of self-harm: *Thoughts that you would be better off dead, or thoughts of hurting yourself in some way?* (Kroenke et al., 2001). Some researchers have addressed considerations for suicidality based on this item (Jacobson et al., 2022; Whitton et al., 2021).

In general, suicidality is a highly sensitive topic and may be tricky to include in an online screening tool. Jacobson et al. (2022) found that although online screening tools may influence help-seeking behavior, "referrals to in-person treatments could put individuals at a greater risk of active suicidal intent" (p. 276). However, most of the time, these referrals were static links and not dynamically presented with clear calls-to-action (Jacobson et al., 2022). Without proper calls-to-action, they theorized that the referral initiation process may have been overwhelming for some people and did not feel encouraged to follow through (Jacobson et al., 2022).

In Whitton et al. (2021)'s study of a virtual screening tool, a score of 1 or more on item 9 was flagged to the primary care provider (PCP) in a separate area in the patients' screening results. PCPs were provided with various ways to support patients whose screening was flagged "including providing prompts to help initiate a discussion with the patient regarding their responses on the screener, steps for further assessing risk, information describing how to develop a safety plan for patients who are actively suicidal, and links to relevant local and national crisis services" (Whitton et al., 2021, p. 2021).

Benefits of psychoeducation

Adding psychoeducation to virtual screening reports has been shown to be beneficial in perinatal settings (Kingston et al., 2015) and in primary care settings (Whitton et al., 2021). In perinatal settings, participants were more likely to engage in screening if they knew that there were explanations behind why sensitive questions were being asked as well as self-help around emotional struggles (Kingston et al., 2015). In a primary care setting, two-thirds of the participants who were prescribed self-guided web-based interventions reported using the intervention initiality, although researchers did not determine rates of ongoing engagement (Whitton et al., 2021). The other web-based option was guided therapy. Interestingly, out of both web-based interventions, the majority of people who were prescribed to web-based self-help used it while only about half of people who were prescribed to guided web-based therapy reported using it.

It is unclear how many participants were prescribed to both types of interventions so preference of self-help over guided therapy is unknown (Whitton et al., 2021).

Final considerations

For youth populations, there is a need for strong psychometric tools that measure disordered eating, suicidality, psychosis, and substance use (Becker-Haimes et al., 2020; Beidas et al., 2015) that are specifically built and tailored to this age group, rather than "downward extensions of adult measures" (Becker-Haimes et al., 2020, p. 10). Positive screening in these areas in youth populations should be followed-up with a clinical assessment to confirm a positive screen.

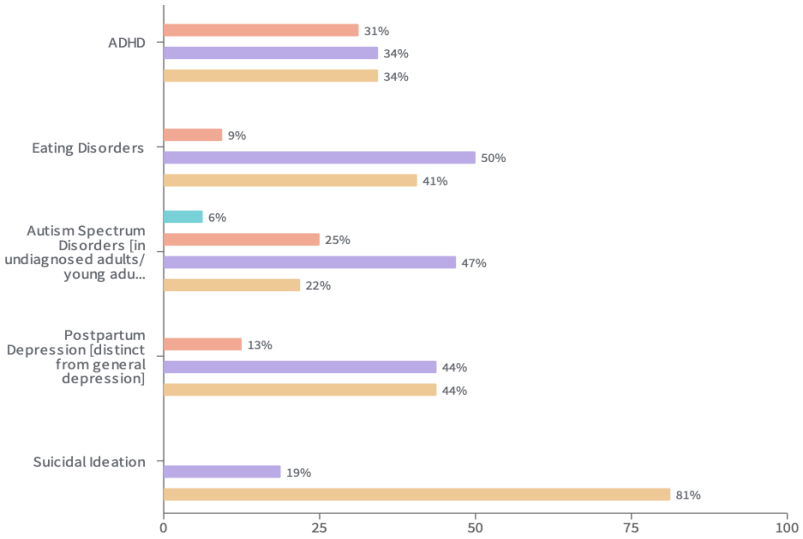
When implementing self-administered screening, some researchers discuss concerns that a universal screening approach would lead to an increase in referrals (Forbes et al., 2019). Forbes et al. (2019) enlisted the help of graduate students to help reduce demands on campus mental health professionals. Kingston, Austin, et al. (2017) argue that having virtual screening can reallocate "scarce human resources to where they are most needed—in-depth follow-up assessment, referral, and treatment" (para. 6) and Krausz et al. (2018) argue a similar case.

One way to limit referrals is through decision theory. Smits et al. (2007) conducted a study that examined how decision theory can be used to determine optimal cut-off scores for different groups. Even though validated screeners usually already have cut-off points that determine severity of risk (i.e. low, moderate, high), optimal cut-off points may be different for different circumstances. For health service providers, false positives can result in increased costs since positive screeners would require in-depth assessments (Smits et al., 2007). Therefore, cut-off points may be altered to ensure that the amount of potential false positives does not create a huge burden of cost on the system.

Finally, for additional best practices for self-administered screeners for a Spanish-speaking population, Aponte-Riviera et al. (2015) argue that creating clinics and health centers specifically dedicated to serving Latinx populations can help target the issue of underrepresentation in research studies. They also suggest that "an understanding of cultural variables, the recruitment of bilingual and bicultural staff, and the development of partnerships with community agencies are essential" (Aponte-Riviera et al., 2015, p. 5).

4. Considerations and Questions for MCBH

Several considerations and questions were raised from focus group and interview participants, the literature review, and the Clinical team. The first part of this section outlines content considerations for seven additional conditions to include in the screening tool. All seven were mentioned by focus group and interview participants. The



needs assessment survey (N=93) also included a question about other conditions to include in the tool in which MCBH professionals were asked to *Please rate how important you think it is to include each additional item* (left). If the County decides to include screening for one or more of these additional conditions, the team would determine the best scale or survey to use during the Development phase of the screening tool. The second part outlines specific questions we have for the County, all of which would affect the development of the tool.

A. Pregnancy and parenting-related depression

Based on findings from the needs assessment, we are recommending to include screening for pregnancy and parenting-related depression using the Edinburgh Postnatal Depression Scale. We would include a screening question to determine pregnancy or childbirth status. For example: *Are you currently pregnant or have you been pregnant within the past two years?* If the user responds *Yes*, then they would see questions for this particular scale. If *No*, then they would see questions related to general depression.

B. Suicidality and self-harm

Several focus group and interview participants advocated for including a measure or question to assess for suicidality or self-harm risk. There are ethical as well as technological implications to consider if the County ultimately chooses to include screening for these sensitive topics. We have outlined three scenarios:

Scenario 1—**Don't ask at all**. If a scale includes a question asking about suicidality or risk of self-harm, then we could remove the question. For example, the PHQ-9 asks a user to determine how often they had "thoughts that [they] would be better off dead or of hurting [themselves] in some way" (PHQ-9 source). In this scenario, we would remove this question though there are still opportunities to display relevant resources. In a user's results page, there can be a section with resources under *What to do if you are experiencing thoughts of self-harm* that can be triggered if the user's results indicate high risk or concern for depression or trauma. In the general resources page, relevant resources can be added for anyone to access.

Scenario 2—**Assess for a non-specific level of risk and provide information to relevant resources**. If the County decides to include screening for suicidality and self-harm, then we could include the above question in the PHQ-9 or add a similar question that assesses a non-specific level of risk. Since the question asks about "thoughts" of suicide or self-harm, a level of risk cannot be determined as opposed to if the question asked about intent or a plan. If a user responds to this question anymore than the minimum response, than their results would automatically display the suicide hotline number, suicide prevention information, and other related resources.

Scenario 3—**Assess for level of urgency and help stratify risk.** If the County decides to include screening for suicidality and self-harm and would want to ask questions to determine any level of need or risk, then this warrants a plan for an immediate safety response. An immediate safety response would entail someone monitoring screening tool

results regularly and being able to follow-up via call or text if a user's results triggered a safety response. Because we recommend not requiring users to provide contact information, we do not recommend Scenario 3.

C. Trauma

Some participants advocated for including trauma screening in addition to PTSD screening as not all trauma qualifies for a PTSD diagnosis. There are options to screen for traumatic life events using a scale such as the Life Events Checklist for DSM-5 (LEC-5) or Adverse Childhood Experiences (ACEs) Questionnaire for traumatic events that occurred during childhood.

D. Eating disorders

Some participants advocated for screening for eating disorders, especially since 16 is the minimum targeted age of the screening tool. We are aware that there are very few local resources and services for eating disorders in Monterey County, but CredibleMind would be able to provide self-help resources for users who meet the threshold to see these resources.

E. General mental distress

A few participants advocated for screening for general mental distress in place of screening for each individual condition. We recommend that a general mental distress scale be added in addition to screening for individual conditions. There may be situations where users do not meet cut-off criteria for a specific condition but screen positively for some mental distress and would still benefit from being referred to self-help resources or local resources. The World Health Organization's Five Well-Being Index (WHO-5) is an example of a good brief general mental distress scale.

F. Social determinants of health

Several participants advocated for screening for social determinants of health (SDoH)—mainly, transportation access was cited as a huge barrier for clients and insurance status was cited as primary criterion to determine a client's referral pathway. There are validated measures that assess for various SDoH factors such as food security and housing that can be included or we can have a general checklist of factors and ask people to designate which factors they may need assistance with. If the County chooses to include screening for SDoH factors, then the Development team would collaborate with United Way in order to link to the 211 system and/or the Smart Referral Network software.

G. Questions for MCBH

This section outlines questions we have for MCBH that will help to inform the development of this screening tool.

- **How should we approach screening for suicidality or self-harm risk?** See Section B: Suicidality and Self-Harm for more information.
- **How should we approach crisis or at-risk situations in general?** If a user scores severely in any condition, we plan to display hotlines, text lines, etc. in their results. Does the County have specific recommendations or things they would want to see in a results page for a user who is "in crisis"?
- **From the Clinical team: Should we include screening for Behavioral Addictions? What about Borderline Personality Disorder?** Some substance use scales and surveys that screen for alcohol and drug misuse also include screening for behavioral addictions (i.e. gambling, video game addiction, sex addiction). Is this important to the County to

include? In addition, we are contracted to screen for bipolar disorder which is commonly misdiagnosed as borderline personality disorder (BPD) and vice versa as both conditions share symptoms (Zimmerman et al., 2010). Does the County want to include screening for BPD?

- **How "close" should we get to a diagnosis?** Based on the needs assessment, many providers gave feedback that this tool should not be diagnostic. Though we will not tell users directly that they have a diagnosis, some of the scales we are considering including can assess whether a person is at risk or not and if at risk, assess further if they meet diagnostic criteria. For many scales, users only need to respond to the first few questions and depending on their score, they can continue on to the rest of the scale (i.e. a positive screen) or stop (i.e. a negative screen). For the screening tool, if a user screens positively we can 1) continue displaying the rest of the questions for that condition to get "closer" to diagnostic criteria or 2) stop at the point of a positive screen. Regardless if the screening tool determines that they may meet diagnostic criteria, users will still be referred to ACCESS and other resources.
- **Other than SDoH, what other information does MCBH need to know from clients?** Based on the needs assessment, we recommend asking about transportation and insurance status. We also recommend asking about age, gender, and language preference which are standard demographic questions to ask in comprehensive screening tools. What other information is MCBH interested in? Examples include physical health or medical status, employment, or previous or current history within ACCESS/MCBH.

3.2 Needs Assessment

1. Description of Process

From October 2021 to November 2021, the CredibleMind Research team developed focus group and interview protocols[8] as well as a survey[9] to disseminate to individuals in Monterey County for the needs assessment.

Focus groups and interviews: We conducted a pilot focus group with 3 individuals on November 19, 2021 to test the protocol. Afterward, we engaged with our MCBH contacts to recruit additional participants. Recruiting continued from December 2021 to February 2022—our MCBH contacts spearheaded connecting us with potential participants and forwarding contact information to the Research team for follow-up.

In a four-month span, we conducted 7 focus groups (including the pilot) and 3 interviews with a total of 29 participants. Participants ranged from ACCESS providers, MCBH staff, professionals from community agencies, and general community members. All participants provided informed consent prior to the focus group or interview session.[10] All focus groups and interviews were conducted via Zoom in English. Participants were shown a brief slide deck describing the project and key stakeholders.[11] Eight participants were community members (not representing a professional agency) and each was compensated with a $40 gift card for their participation. We also developed a brief optional survey for participants to complete after the session in case they wanted to submit feedback or comments anonymously but did not receive any feedback that added to our prior knowledge base. Please see 2. Summary of Findings below for more details on the outcomes of the focus groups and interviews.

Survey: Along with the qualitative methods mentioned previously, the Research team developed a survey for people who live or work in Monterey County to augment the needs assessment with quantitative data. The survey was created via a website called Survey Sparrow and two pathways were developed: one for MCBH professionals and one for community members. The community member version was translated into Spanish by a native Spanish speaker. The survey officially launched on January 20, 2022 and closed on February 28, 2022. We offered an incentive for community members by promoting a drawing to win one of fifteen $50 gift cards upon completion of the survey in order to increase participation.

We initially marketed the survey by emailing it to a list of email addresses of 240 Monterey County professionals and community members. We also reached out to former focus group and interview participants as well as other local organizations and agencies, such as public libraries and Monterey County United Way, and asked them to share the survey with their constituents. MCBH posted our survey marketing and promotion materials on their social media platforms.[12] In total, we received 93 responses, 32 who indicated they currently work for MCBH and 61 who did not. Please see 2.0 Summary of Findings for more details on the survey.

[8] See Appendix D: Focus group and interview protocols
[9] See Appendix E: Copy of final survey
[10] See Appendix F: Informed consent letter
[11] See Appendix G: Slide deck for focus groups
[12] See Appendix H: Survey marketing materials

2. Summary of Findings

Below is a summary of findings based on the three research goals outlined in the statement of work. For focus groups and interviews, we had 29 participants total: 16 MCBH professionals, 8 community members, and 5 professionals representing other community agencies that provide mental health support or sometimes interact with MCBH. For the survey, we received 93 responses: 32 who selected *Yes, I am an MCBH employee or work for MCBH"*and were directed to questions in the MCBH professional pathway and 61 who selected *No, I am not an MCBH employee nor do I work for MCBH* and were directed to questions in the community member pathway. Survey results can be found in Appendix I. Most of the information in this section are considerations expressed by Monterey County community members and professionals and gathered from focus groups, interviews, and the survey. Some information was retrieved from an internal draft of results from EVALCORP's annual MCBH needs assessment which MCBH contacts provided to CredibleMind and other information was retrieved from MCBH's FY 2020/2021 Data-Driven Decisions (D3) report which is publicly available (Monterey County Behavioral Health, 2021).

Goal 1: The perception of need from mental health and behavioral health agencies, the patients, and their family members/friends

Meeting the diverse needs of Monterey's diverse community

- When asked if the triage/intake process is able to meet the diverse cultural needs and preferences of the Monterey County community, 30% of surveyed MCBH staff disagreed
- When asked about the availability of culturally aligned and language accessible resources, 42% of surveyed MCBH staff reported that it "needs some improvement" and 11% reported "needs significant improvement"
- Both professionals and community members expressed a need for more Spanish- speaking providers as well as greater capacity for providing services and information in indigenous Mexican languages such as Triqui, Zapoteco, and Mixteco. These sentiments echo the findings within MCBH's own annual needs assessment.
- Services that are welcoming and uplifting of LGBTQIA2+ community members are limited. It's difficult to determine if services are accepting of all sexual/gender identities.

  A young adult focus group participant related:

  "I have a lot of intersections—intersecting identities with my gender, my sexuality, my Hispanic background, and just certain experiences that I went through. If I don't have a professional who's like, I don't know, Spanish-speaking or who understands where I'm coming from culturally, or have some training in like the LGBT community, I don't feel as comfortable because I feel like I have to put up a face."

Clearer and more transparent communication around the service-seeking process

- 55% of surveyed MCBH staff felt that clients did not have appropriate expectations or understanding of the triage and intake process.
- ACCESS representatives shared that triage and intake appointments

sometimes last very long because people believe they are beginning therapy during the initial consultation.
- Community members reflect on not being told or not understanding that they may have to talk to more than one person before beginning treatment with a clinician. They also lacked information on expected timelines and expectations of the role they played in their own treatment. Many individuals expressed confusion about whether they themselves or the staff member working with them was responsible for reaching out to referred services, initiating scheduling, or similar tasks.

More services for specific populations

- The underserved populations that were most frequently mentioned include people seeking treatment for disordered eating, people seeking help in South County, and individuals without health insurance who had less than severe mental health concerns.
- When asked about availability of resources for most needs, 42% of surveyed MCBH clinicians responded "needs significant improvement" and an additional 37% responded "needs some improvement".
- In terms of screening and assessment specifically, parents want more tools to be able to identify mental health challenges in their children. People have noticed more mental health challenges in their children since the onset of the pandemic. Barriers such as lack of transportation, lack of time, stigma, and lack of mental health services at schools make it more difficult for parents/caregivers to effectively procure help and information.
- MCBH recently completed their annual needs assessment in which they surveyed 276 providers and 200 community members. 85% of providers indicated that "services were available to communities and regions they served, but were insufficient to meet the need" (Monterey County Behavioral Health, 2022). In general, they reported that:
    - 66% of providers indicated this insufficiency specifically for low-income individuals
    - 65% for individuals exposed to trauma
    - 64% for individuals experiencing homelessness
    - 62% for individuals who primarily speak Spanish

Improved coordination and continuity of care

- When asked if they can easily and reliably share necessary client information with providers outside of their organization or department, 20% of surveyed MCBH staff strongly disagreed and 45% disagreed.
- Community members who participated in the focus groups expressed a range of related concerns. Some felt like they had to "start from scratch" with each new provider they were referred to and felt frustrated by answering similar questions multiple times. Others felt blindsided by the information that was passed between providers and desired more opportunities to give consent and improved communication around information that is shared.
- Improved systems of sharing information within and between agencies is necessary to improve the screening/triage, assessment, and referral processes

for both clients and providers.

Goal 2: The barriers and facilitators to accessing mental health information, screening, and services

Barriers

Lack of providers

As is the trend nationally, the demand for mental health providers exceeds the supply in most areas. Community members recount times where they had to wait six months or longer to begin receiving the services they were primarily referred for. Particularly for people who are reluctant to seek mental health support in the first place, this can be a major deterrent to continuing care and an exacerbating factor to their current mental health. MCBH staff who completed the survey advised that more resources should be given towards staff retention efforts.

Though the expansion of telehealth has increased access to care, many people still express a preference for being seen in person. As mentioned in the previous section, geographical areas such as South County have a dearth of mental health providers. Clients are sometimes unable to access services due to lack of transportation and/or lack of services in proximity to their residence.

As also mentioned above, another barrier to care is lack of culturally representative clinicians. Community members feel that it is very important to receive services from people who speak their language and can relate to their background and life experiences.

Lastly, many people are unable to access mental health services during normal business hours. Providers who are able to see clients in the evening or the weekends would increase accessibility.

Lack of information on available services

- Aside from certain areas of need, there are many mental health resources in Monterey County but professionals and community members expressed having difficulty staying aware of what services exist—48% of surveyed MCBH staff said that their familiarity with available resources or their ability to access a directory of resources "needs some improvement" or "needs significant improvement" and 69% felt that it is difficult to get accurate up-to-date information on community resources. During a focus group, one community member expressed:

  "I know that for emergency, I go to CHOMP. But if I have a collapse, for example, mental collapse or mental breakdown, where should I go? What can I do? "

Besides a general internet search, United Way 211 and a resource guide called SAM's Guide (McNelley, n.d.) were the primary directories utilized to identify mental health resources. Many MCBH staff said that they often create their own resource lists.

MCBH received similar concerns on their annual needs assessment:

> *"Participants stated that the lack of knowledge about where to get help was a key barrier along with cost, long wait lists, and the locations of services*

being far. They expressed that program staff were working to meet the needs of those they served, but they lacked the knowledge of where to send individuals who needed different services than their specific program provided. Participants suggested that providers be more educated about services in the area and that awareness be raised by using flyers, teachers informing students, and a community liaison or hot line. They also suggested having an online site to go to that shows the services provided and insurance types accepted " (EVALCORP, 2022).

Stigma and misinformation

Though society is generally becoming more welcoming of discussing and addressing mental health needs, many people in Monterey County identify stigma as a primary barrier to seeking help and accessing care. Community members' ideas around mitigating stigma and misconceptions included:

- Culturally relevant messaging in various languages (via social media and Whatsapp in particular)
- Receiving information from within the community—people want to hear from people who look like them and have similar backgrounds. Videos of either community members talking about their experiences receiving support in Monterey County or of Peer Support Professionals (similar to the Vida Community Health Worker Program) help people feel more willing to receive the information
- Enlisting organizations like Centro Binacional para el Desarrollo Indígena Oaxaqueño (CBDIO) to develop mental health material in indigenous Mexican languages
- Promoting anonymous ways of obtaining support and information (such as the online screening tool being developed in this current project)
- A guide or program called "Introduction to Mental Health in Monterey County" could be used to educate new employees across various sectors. Public school educators, in particular, could receive training on how to recognize mental health symptoms in their students and refer them to the appropriate outlets.
- In some unique scenarios, individuals have expressed fear that seeking mental health support will have negative legal repercussions such as in cases of intimate partner violence or immigration.

Unclear eligibility requirements

In the survey results, 58% of MCBH staff expressed difficulty ensuring that clients are eligible for services they might refer them to and 73% of MCBH staff said that clients' ability to get in contact and register with referred services "needs significant improvement" or "needs some improvement".

Though MCBH's "No Wrong Door" practices appear to have a positive impact on the accessibility of mental health services, community members still express feeling uncertainty about where they should seek care based on what they are experiencing, their insurance status, financial capacity, and other factors. They also expressed feeling frustrated when being referred away from their initial point of contact. For example, ACCESS providers have to call referral organizations to confirm their availability and eligibility requirements since this information fluctuates frequently. This sometimes increases the amount of time clients have to wait to begin treatment or requires them to switch providers.

Facilitators

Increased availability of virtual appointments

Community members appreciate being able to receive care virtually since it offsets any transportation/location barriers. It also saves people time and money as they do not have to leave their job or find childcare in order to take an appointment

ACCESS professionals describe how virtual appointments allow certain segments of the population to be reached more easily. Conversely, some clients demonstrate decreased motivation or engagement when meeting virtually—there can be hindering technical difficulties or there can be more back and forth when trying to schedule appointments.

"No Wrong Door" practices

County mental health providers are working hard to not turn away anyone who is seeking services regardless of that person's initial entry point to the system. At ACCESS locations, anyone who calls or presents to a clinic seeking support will at least receive some information on where they can obtain help even if they may not be eligible for services with MCBH directly.

Interpretation services and bilingual practitioners

Though there is a need for more language accessibility, many people expressed appreciation and satisfaction in their ability to access care in their preferred language.

Information sharing between providers

In cases when there are accessible ways to share information between two providers and it's done in a timely manner, this leads to positive outcomes for both the client and the providers.

Monterey County United Way 211 and Smart Referral Network (SRN)

Both providers and community members utilize 211 to identify local resources that match their needs. The 211 SRN system, in particular, maintains up-to-date information on all involved providers and implements a bidirectional referral process. This means that providers in the SRN system are able to follow up with clients on whether they were able to access services and provide support throughout that process. Currently, the referral process conducted through ACCESS/MCBH is not a bidirectional process.

Goal 3: The perception and community preferences of using technology for mental health screening and access from providers, patients, and their family members/friends. Cost considerations for implementation of various types of virtual screening tools

Access to technology

Monterey County residents that participated in CredibleMind's needs assessment expressed concern for the potentially large swaths of the population who lack internet access via phone and/or computer. School and library computers were common points of internet access mentioned by community members as well as using free wi-fi hotspots at places like fast food restaurants.

Comfort with using technology

Those who may have internet access may not be comfortable with using technology for a variety of reasons. Certain portions of the population are more likely to have low digital literacy such as older generations and certain subgroups within the migrant communities. Some people are often wary of receiving or providing information on the internet since it can be difficult to gauge the trustworthiness of a particular site and know how one’s personal information is being used.

Accessibility

Since some level of reading is required to navigate most technology, there are concerns around people who lack reading literacy. Having audio buttons that read on-screen text out loud can be supportive in these cases. One way that technology increases accessibility is that access to it is not barred by time or location. People can utilize online resources on their own time and transportation would not be a barrier. The immediacy of access to information the internet can provide is also beneficial at times.

Privacy preferences

The anonymity of the internet may make it easier for people to seek support for things that they may not feel comfortable doing publicly. As previously mentioned, stigma is a major barrier to mental health services which makes digital services an important option and opportunity. People with social anxiety and younger generations may also find the internet a more accessible space.

Technology may allow individuals to initiate care at their own pace. For some people, finding preliminary information or self-help resources online can be a less jarring way to begin their mental health journey as opposed to starting off by talking to a clinician directly.

Additional considerations for online mental health screening

Though many people expressed numerous benefits of technology, many of the same people also shared that they prefer human connection when it comes to mental health care. A lengthy online screening has an even greater risk of losing people's engagement and motivation. The sensitive nature of mental health topics also presents a risk when people may be confronted with difficult themes while in a distressed state. It will be important to be intentional about the language used in an online screening and to inform people how to get immediate support if needed.

- In more severe cases, such as people who demonstrate high risk for behavior that would harm themselves or others, there are qualms around how such situations would be addressed to not only ensure safety but also protect people's privacy and right to consent.
- Another unique population subset that may struggle with online mental health screening is people experiencing schizophrenia or other types of psychosis. There may be more paranoia around using an online screener especially since it asks direct questions about mental health.

Aggregate data from screening results could provide some insight into the population-level mental health of the County. It is important to consider, though, that 1) people have a tendency to underscore or under-report when answering questions about themselves and 2) a self-screener is not a diagnostic tool.

On an individual level, online mental health screening can boost autonomy by providing people with language and context with which to discuss their mental health concerns. One young adult focus group participant felt that an online assessment could be a self-advocacy tool in times where they perceive that a provider is downplaying their concerns.

Sharing online mental health screening results with a provider can also help cut down on time spent on triage and can provide supplementary information to a person's health record. With this preliminary information, providers can begin to gauge probable severity/acuity and be able to address a client with a more trauma-informed approach. An MCBH supervisor suggested that clients and providers have access to

the same format of results so that clients do not feel blindsided by any information shared.

Mental health professionals that we spoke with expressed a desire to be able to track whether a person used or accessed any resources recommended to them upon completion of online mental health screening. Community members also discussed wanting the option to receive follow-up after taking a self-screening.

Cost considerations for implementation of various types of virtual screening tools

The initial cost considerations for implementing a virtual screening tool is research and development of the product. For this current project, CredibleMind was contracted at a total cost of about $810,000 to research and develop the tool. Once the tool is created, the ensuing costs include implementing the tool in the County ($30,000-$60,000 depending on population size), training staff on utilization of the tool (~$51,000), post-go live support (~$48,000), and ongoing maintenance and support of hosting the platform post-launch ($8,000 per year). Since the virtual tool is intended to be a self-screener, staff training would mainly involve orienting people to the content of the tool and instructing them how to use any sharing capabilities such as viewing a client's screening results or adding results to client charts. The complexity of staff training will depend on what features and functionality are agreed upon during the development phase.

An additional cost consideration is keeping referral resources up to date, whether that is on CredibleMind, in which the cost would be for the assignment of an official account manager or on MCBH, in which the cost would be related to staff time to review and update resources on a regular basis.

Aside from the initial implementation fee of $30,000 and ongoing hosting costs of $8,000 per year, additional costs for MCBH and ACCESS post-launch are difficult to predict. MCBH's goal of implementing an online screening tool is to mitigate the increased burden on mental health providers as more and more people are seeking services. A self-screening and referral tool can help divert individuals from ACCESS if they may be better supported receiving care from a different provider, but there is also the possibility that more people will seek out ACCESS services. This tool will likely increase awareness of ACCESS services as an available resource and cause more people to consider seeking mental health support for the first time. Based on numbers in MCBH's FY 2020-2021 D3 report, "assessment/evaluation" services make up 13% of total services but take up 26% of the total service minutes. "Linkage/brokerage" services make up 31% of total services but take up 25% of the total service minutes. A virtual screening tool can help shift resources away from these two areas so that providers can spend more time providing direct treatment.

Efforts to increase utilization of the tool creates another additional cost consideration. Our discussions with professionals and community members raised suggestions such as:

- Providing tablets or creating kiosks in ACCESS clinics where people who lack internet access or digital literacy can take the tool
- Training peer support workers who can promote the tool in the community and also aid people with completing the tool in-person at ACCESS clinics
- Developing widespread marketing efforts in community places where people gather such as the hospitals, library, and laundromats

For community members, the singular cost consideration surrounds having access to a device and sufficient data/wi-fi to complete a virtual screening tool.

Suggestions on the features and functionality of the current screening and referral tool project

offered by CredibleMind survey respondents

- "Spanish marketing! A bigger Facebook presence in Spanish-speaking communities. Perhaps reaching out to Spanish local trusted agencies like church & radio stations "
- "Emphasize that treatment is available from providers other than psychiatrists and psychologists (licensed social workers, marriage and family therapists, Papillon Grief Services, etc) that are much less expensive than traditional treatment. Also these providers may have more frequent openings than MDs and PhDs whose practices are full. "
- "A brief explanation of what the mental condition is and an example of a famous person who had the same condition. That would help to normalize mental health. "
- "Treatment success rates for particular categories of services or issues "
- "Positive affirmation throughout the process and crisis line information "
- "A list of mental health conditions from which to select a screening exercise. "
- "Financial assistance providers for services such as Medi-Cal eligibility, low-cost insurance providers, local nonprofits who can provide financial assistance, or other ways to cover the cost for services. "

3. Discussion

The questions, opinions, and suggestions presented by Monterey County community members and professionals throughout this needs assessment process are fundamental contributions towards ensuring that this virtual screening tool is shaped in such a way that best meets the needs of the community. Some of the overarching concerns presented across different topics include the perception that there are not resources available for specific needs or populations, unclear communication and expectations surrounding the help-seeking and referral process, stigma, and the accessibility and safety of a virtual screening tool.

Though this tool is not creating new programs or services, people can be more efficiently linked to local resources tailored to their needs and also be made aware of online self-help tools, therefore expanding their awareness and options for care. Expanding the horizons for support can help historically underserved populations or people with specialized needs get connected to resources they might not otherwise be aware of. It would also help alleviate the burden on MCBH clinicians, particularly when working with beneficiaries who do not meet the eligibility requirements for MCBH programming.

In regards to unclear communication and expectations, we must ensure that, in the development of this tool, people do not receive information or direction that contradicts with or conflicts with any messaging they receive from providers. CredibleMind is making a continued effort to model the virtual referral experience after current MCBH practices and processes. As a tool that may mainly reach people who are not yet accessing care, there is an opportunity to set a positive and straightforward baseline understanding of the mental health help-seeking process through messaging included on the site. The compilation of information on local resources can also bring providers more direct information around details of services, eligibility requirements,

and more areas which are currently difficult to decipher. This tool is theoretically creating another “door” by which people can enter into care—hopefully, it will help minimize the steps between the point of entry and the point of engagement or treatment.

Providing an online mental health resource comes with a mix of unique benefits and concerns. The privacy and anonymity of a screening and referral tool that someone can take using their personal device helps decrease the barrier of stigma around seeking help for mental health. Unfortunately, not all people have access to the internet or an acceptable device to access virtual screening. Additionally, they may lack the digital competence to be able to utilize such a resource. As mentioned previously, there are numerous suggestions around how we can increase accessibility including having schools or libraries include a link to the screening tool on the desktop of their computers, using peer support workers, and establishing kiosks specifically for screening tool administration at ACCESS clinics. This is not a tool that will necessarily be accessible to or preferred by all members of the community, but it certainly has the potential to serve as a welcoming starting point for many people—particularly, younger generations, people reluctant or unable to seek care in person, and people unfamiliar with the mental health system.

In the future, there may be opportunities to expand the reach of this tool by including screening for children younger than 16, adding additional languages, creating a print or phone-based version, and more. Currently, CredibleMind continues to work with Monterey County to develop an initial product that satisfies the most common and most pressing concerns while achieving its principal goals of alleviating the burden on mental health providers and raising awareness of available resources.

4. Limitations

Conducting this needs assessment during the Covid-19 pandemic, which meant having to recruit, promote, and conduct all focus groups and interviews virtually, was a primary barrier. Since we could only conduct focus groups and interviews via Zoom, participants were required to have access to a device that could connect to Zoom as well as data or internet access to participate. In addition, participant recruitment and promotion of focus groups, interviews, and the survey all had to be conducted virtually. Although the statement of work did not state a minimum sample size for the needs assessment, the CredibleMind Research team set target goals of 20-40 participants for focus groups/interviews and 100-200 respondents for the survey. We may have had increased participation and obtained more diverse perspectives if we were able to recruit and conduct research in-person in Monterey County—for example, by tabling in public spaces and asking passersby to complete the survey or going to community agencies and doing outreach for the focus groups and survey.

This limitation also affected our ability to conduct a focus group in Spanish with Spanish language-preferred individuals. To mitigate this limitation, we prioritized recruiting bilingual or multilingual community members and providers who were able to offer us perspectives from within the Spanish-speaking and indigenous Mexican communities in Monterey County.

The needs assessment for this project was also conducted on a timeline that overlapped with MCBH’s annual needs assessment. With nearly identical target populations, MCBH staff members and Monterey County community members were being recruited for multiple surveys, focus groups, and interviews around the same time. The various requests for participation may have felt overwhelming—"survey or respondent fatigue" is a known limitation in needs assessment processes and our efforts coupled with MCBH's efforts

likely led to lower survey response and focus group involvement rates.

3.3 Behavioral Health Systems Map

1. Description of Process

From October 2021 to February 2022, the CredibleMind Research team found approximately 200 programs and services in Monterey County related to mental/behavioral health and other related needs using Google, the MCBH website, and MCBH contacts. Resources were initially categorized into a spreadsheet as either mental health resources or "related resources" for services that address other social determinants of mental health.[13] These broad categories were further broken down into various mental health conditions (i.e. trauma, grief/loss, substance use) or other topics (i.e. housing, employment, parenting). In collaboration with MCBH contacts, a form was created that would log more specific information about each resource (i.e. contact information, description, accepted insurance) and populate it into a more comprehensive spreadsheet.[14] Gathering and maintaining the most up-to-date information for these resources will be a continued effort, but the framework has been created so that screening tool results can be populated with this information and MCBH professionals will have additional means for cataloging resources.

Historical data regarding populations served and in need of services for each county, most common mental health conditions, existing services and associated costs for accessing mental health services, and key behavioral health performance measures were gathered from publicly available reports produced by Monterey County.Please see Section 3: Mapping of General Mental Health Landscape for more information.

2. Mapping Counts of Programs and Services

The following outline illustrates the categories of the initial spreadsheet and counts of identified resources. This is by no means an exhaustive list of local programs and resources in Monterey County. As mentioned previously, it serves as a starting point and is likely to grow and expand over time. Please see Appendix J for a copy of the full spreadsheet which includes the name of each resource.

Mental Health Resources (Total count = 107 resources)	**Related Resources (Total count = 99 resources)**
• General Mental/Emotional Health = 29 resources • Substance Use = 33 resources • Youth = 25 resources • Trauma = 16 resources • Birth Support = 3 resources • Grief/Loss = 1 resource	• Physical Health = 14 resources • Housing = 22 resources • Disaster Relief = 1 resources • Internet = 5 resources • Veterans Affairs = 3 resources • Nutrition Services = 11 resources • Employment = 5 resources • Youth Development = 5 resources • Parenting = 16 resources • Immigration = 6 resources • Transportation = 1 resources

[13] See Appendix J: Original systems mapping spreadsheet
[14] See Appendix K: Systems mapping entry form

	• Seniors = 2 resources • Education/Literacy = 2 resources • Caregiving = 3 resources • Deaf/Hard-of-Hearing and Blind = 3 resources

3. Mapping of General Mental Health Landscape

The majority of the information compiled in this section of the report comes from annual data collection compiled by Monterey County government entities. Publicly available documents such as the Monterey County Health Behavioral Health D3 Data Driven Decisions FY 2020/21 report and the most recent years of MCBH and EVALCORP's Mental and Behavioral Health Needs Assessment Summative Report served as the primary sources of information.

Key populations served and in need of services

Fiscal Year 2020-2021 D3 data for Monterey County Behavioral Health System of Care	
13,156	Total Clients Served by Monterey County Behavioral Health System of Care
49%	Male
51%	Female
52%	Latino/a/x/e
48%	Not Latino/a/x/e
17%	Spanish is preferred language
4%	Other language (not English or Spanish) is preferred
411	Age 0-5 clients
3,042	Age 6-15 clients
2,961	Age 16-25 clients
6,094	Age 26-59 clients
1,050	Age 60+ clients
2020 EVALCORP Provider and Community Member survey data ("*The Provider Survey was designed to gather feedback from a broad range of people, agencies, and systems who work directly with persons who are receiving or are in need of mental health services. Respondents invited to take the survey represented multiple service sectors, such as education, law enforcement, hospitals, and other community service agencies and organizations.*")	
79%	Provider respondents who serve persons who are low-income
72%	Provider respondents who serve persons who are trauma-exposed

57%	Provider respondents who serve persons experiencing homelessness
54%	Provider respondents who serve persons experiencing onset of serious psychiatric illness
53%	Provider respondents who serve family members, support persons, or caregivers of individuals with mental health conditions
42%	Provider respondents who serve in the Coastal Region
32%	Provider respondents who serve in North County
75%	Provider respondents who serve in Salinas Valley
36%	Provider respondents who serve in South County
Depression, Substance use, Chronic Stress	Top 3 Community Member respondents' mental and behavioral health issues that were most urgently in need of additional resources
Depression, Substance use, Trauma	Top 3 Provider respondents' mental and behavioral health issues that were most urgently in need of additional resources
Top ten population types that Provider respondents felt had insufficient available services to meet the need or no services available at all. *Percentages represent how many provider respondents selected each population*	
89%	Persons who primarily speak a language other than English or Spanish
87%	Persons experiencing homelessness
86%	Persons with disabilities other than mental/behavioral health conditions (e.g., mobility, hearing, speech, learning, developmental, chronic health conditions like HIV or diabetes, etc.)
86%	Family members, support persons, or caregivers of individuals with mental health conditions
84%	Persons who are low-income
84%	Children/youth at risk of juvenile justice involvement
84%	Children/youth at risk for school failure
83%	Persons who identify as LGBTQ+
83%	Persons who are trauma-exposed

Most common mental health conditions

Fiscal Year 2020-2021 D3 data for Monterey County Behavioral Health System of Care	
Top 3 Primary Diagnoses of entire Behavioral Health System of Care clients	
28%	Anxiety Disorders
25%	Mood Disorders
13%	Substance Related Addictive D/O
Top 3 Primary Diagnoses of ACCESS to Treatment clients	
32%	Anxiety Disorders
25%	Mood Disorders
5%	Schizophrenia Spectrum
Top 3 Primary Diagnoses of Adult System of Care (ASOC) client	
50%	Schizophrenia Spectrum
30%	Mood Disorders
9%	Substance Related Addictive D/O
Top 3 Primary Diagnoses of Children System of Care (CSOC) clients	
43%	Anxiety Disorders
23%	Mood Disorders
10%	Disruptive Behavior Disorders
Top 3 Primary Diagnoses of Crisis Hospitals and TAR clients	
36%	Mood Disorders
18%	Schizophrenia Spectrum
15%	Anxiety Disorders

Existing services and associated costs for accessing mental health services

Fiscal Year 2020-2021 D3 data for Monterey County Behavioral Health System of Care		
Overall Monterey County Behavioral Health System of Care *Monterey County Behavioral Health System of Care provides services to all age groups. As a safety net provider, Monterey County Behavioral Health strives to align the services we provide with the needs of the general Medi-cal population. We strive to provide community based*	13, 156	Number of Clients Served
	$8,525	Avg Service Value per Client

services that equitably engage our community members.	$112,155,625	Total Service Value
ACCESS to Treatment *Access to Treatment programs are the primary entry point for eligible county residents of Monterey County seeking mental health services. After an initial assessment, treatment services are typically provided in group settings and/or individual counseling sessions that focus on skill-building*	6,109	Number of Clients Served
	$2,332	Avg Service Value per

and support.		Client
	$14,250,818	Total Service Value
Adult System of Care (ASOC) *MCBH staff collaborates with local agencies to provide a range of services to adults ages 18 years and older with serious and persistent mental illness.* *The overarching goal is to help consumers establish and/or maintain independence, self-sufficiency and recovery through the provision of integrated healthcare services that includes psychiatric, mental health, physical health and case management services. These services are provided at locations in three (3)regional clinics (Monterey Peninsula, Salinas, and Soledad/King City). The primary goal is to maintain clients in the least restrictive environment to enhance quality of life.*	2,303	Number of Clients Served
	$16,552	Avg Service Value per Client
	$39,792,994	Total Service Value
Children System of Care (CSOC) *County Behavioral Health staff provides services designed to strengthen families with children with serious mental health needs, ranging from assessment, individual, group and family treatment, and psychiatry services. Supportive services are also offered to parents/caregivers of children and youth ages 0 through 25 to better understand their child's mental health condition, which promotes optimal mental health treatment outcomes.*	3,740	Number of Clients Served
	$19,860	Avg Service Value per Client
	$36,879,543	Total Service Value
Crisis Hospital and TAR *Crisis intervention services are provided by a team of County Behavioral Health staff who intervene in situations where an individual's mental or emotional condition results in behavior that may pose an imminent danger to him/herself or to another. Psychiatric inpatient treatment in a hospital setting is provided to individuals who are gravely disabled or likely to do serious harm. Short-term crisis residential services, an alternative to hospitalization, is available for individuals age 18 and above who are experiencing an acute psychiatric episode or crisis, and who do not meet the criteria for acute psychiatric inpatient care. This service is provided by a local agency. State hospitals provide mental health services for individuals on a forensic commitment, as well as for individuals who are under conservatorship and require a secure treatment setting.*	2,215	Number of Clients Served
	$6,034	Avg Service Value per Client
	$13,366,928	Total Service Value
Substance Use Disorders (SUD) *Services consist of intensive structured recovery support for Monterey County residents age 18 years and above with a primary addiction to alcohol/other drugs. Intravenous drug users and HIV+ clients receive priority admission. Narcotic maintenance services are available to Medi-Cal eligible adults with a primary addiction to heroin or other opiates to stabilize and decrease their addiction. These services are provided by local agencies.*	1,519	Number of Clients Served
	$5,177.55	Avg Service Value per Client
	$17,864,697	Total Service Value

Key behavioral health performance measures

The table to the right was provided on page 22 of the 2020-2021 D3 report. It shows the breakdown of service types, number of services per type, % of total service minutes, and % of clients per type for MCBH ACCESS. This chart is also available for the MCBH system as a whole and each of the other four MCBH entities individually. Signs of this project's success should largely be reflected in ACCESS service numbers. As this tool seeks to inform the triage process and also direct

	Breakdown of Service Type		
	Number of Services	% of Total Service Minutes	% of Clients
Assessment/Evaluation	7,978	26 %	63%
Collateral/Family Therapy	209	0 %	2%
Crisis Intervention	292	0 %	2%
Group Counseling	28	0 %	0%
Linkage/Brokerage	19,066	25 %	72%
Medication Support	3,493	6 %	18%
Mental Health Counseling	4,367	13 %	10%
Non Billable	18,692	14 %	76%
Telemedicine	5,809	14 %	19%
Others	773	1 %	4%
Total	60,707	100%	100%

individuals to readily accessible resources, decreases in the "assessment/evaluation" and "linkage/brokerage" metrics would demonstrate positive impact. Through our discussion with MCBH staff, there also seems to be a focus on shifting the percentage of time spent on assessment towards time spent providing treatment.

Additional key performance measures include raising community member and provider awareness of available local resources as well as increased help-seeking behavior due to less stigma. As seen in this table from the 2020 MCBH/EVALCORP Needs Assessment report, over half of providers and community members consider "lack of information about where to get help" a major barrier to accessing care. According to their findings, 44% of community members and 54% of providers consider stigma to be another primary barrier. These sentiments have been confirmed in the needs assessment data collected by CredibleMind as well.

Table 10. Barriers to Accessing Mental and Behavioral Health Services

	Community Member Survey		Provider Survey		Percent change from 2019 to 2020	
Barrier	2019 (n=177)	2020 (n=50)	2019 (n=153)	2020 (n=82)	Community Members	Providers
Lack of information about where to get help	63%	66%	64%	55%	+3%	- 9%
Cost	46%	38%	59%	39%	-6%	-20%
Stigma related to mental illness	46%	44%	58%	54%	-2%	-4%
Service locations are too far away	37%	10%	56%	34%	-27%	-22%
Lack of transportation	35%	16%	69%	44%	-17%	-25%
Lack of health insurance	31%	24%	57%	44%	-7%	-7%

4. Limitations

Though much of the necessary information can be found online, the CredibleMind research team's physical distance from Monterey County presented some barriers in gathering the most comprehensive and rich information for conducting this systems mapping. Because we do not live, work, or receive care in Monterey County, more time had to be spent building some baseline familitary of the current mental health system and how it operates. We were dependent on our MCBH contacts to connect us to the people, organizations, and information sources necessary for this part of the project—our contacts were also very busy conducting their own County needs assessment and performing regular job duties not related to this project. In addition, not being able to visit locations or speak to people in person due to pandemic health precautions likely hampered the scope of the information we were able to collect.

One piece of information that does not currently exist is a comprehensive resource database or directory for mental health and related needs that is updated regularly. It became the work of the CredibleMind Research team to begin compiling this information in order to meet the goals of the systems mapping deliverable. We reviewed and analyzed multiple, less comprehensive lists and put the information together in a spreadsheet as a starting point. Some of the primary available sources include the MCBH ACCESS intake packet, United Way 211, and SAM's Guide, but each was somewhat limited in its scope based on factors such as intended use and target audience.

The overall research phase has also been quite iterative, thus shapeshifting the scope and intention of the systems mapping portion during the course of its timeline. As Monterey County is the pilot county involved in this project, clarity around the intended use, purpose, and goals of this online self-screening and referral tool continue to be a work in progress.

Lastly, goals involving mapping the costs of mental health services similarly lacked clarity, presenting challenges when trying to determine the information that needed to be collected. Cost can involve many facets, and different stakeholders involved in the research process offered varying insights. On the provider side, cost may signify the value of a service, the amount actually paid for a service (not often the same as value), and/or the cost of running a particular program or agency. When mapping a County health system, the focus can be on the costs for County-run programs or instead, consideration of the cost of services amongst all local providers (those affiliated or contracted with the County and those who are not). On the client side, cost may involve out-of-pocket payment for services, insurance deductibles or payments for services, and even expenses for transportation, childcare, or taking time off work. We included cost information related to the current project that was readily available. More data may need to be collected moving forward in order to provide more information on how the screening tool may be impacting mental health system costs.

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Appendix E: Needs Assessment Survey Results

Feedback for New Monterey County Mental Health Self-Screening Tool

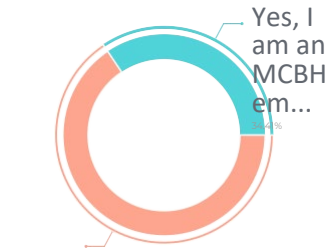
CredibleMind Survey Results

Started
93

Avg. Time to Complete
6m 35s

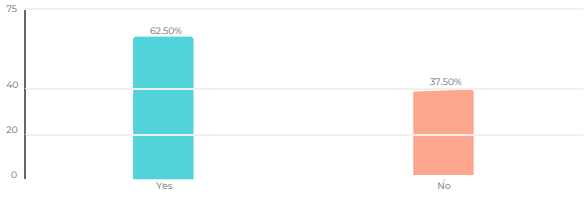
Completed
93

QUESTION 01 | MULTIPLE CHOICE
First, we'd like to know if you currently work for Monterey County Behavioral Health (MCBH) as an employee, contractor, or in any other capacity?
Primeramente, nos gustaría saber si ahora mismo, trabaja para la División de Salud Mental



ANSWER	RESPONSES	RESPONSE PERCENT AG
Yes, I am an MCBH employee or work 32 for MCBH. // Si, trabajo para o soy un empleado/a de la División de Salud Mental del		34.41
No, I am not an MCBH employee nor 61 do I work for MCBH. // No, no soy un empleado/a ni trabajo para la División de Salud Mental del Condado de		65.59

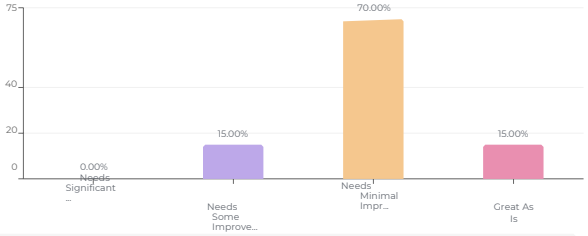
QUESTION 02 | YES O R NO
Do you screen clients for mental health conditions and concerns as part of your job duties?
Screening includes triage and intake



FEEDBACK ON 3

QUESTION 03 | O PINIO N SCALE
On a scale of 1-4, how would you rate the screening process overall?

Answered: **20** Skipped:



ANSWER CHOICES	RESPONSES	RESPONSE PERCENT AG E
Yes	20	62.50%
No	12	37.50%

ANSWER CHOICES	RESPONSES	RESPONSE PERCENT AG E
Needs Significant Improvement	0	0.00%
Needs Some Improvement	3	15.00%
Needs Minimal Improvment	14	70.00%
Great As Is	3	15.00%

FEEDBACK ON SCREENING

QUESTION 04 | MATRIX

Below are some characteristics of screening processes for mental and behavioral health services (screening includes both triage and intake). On a scale of 1-4, how would you rate each characteristic?

Answered: **20** Skipped:

	ST RONG LY DISAG	DISAG	AG
I am able to accurately identify a client's mental health condition based on MCBH/ACCESS	0	2	13
I spend too much time on screening	1	13	4
Clients have appropriate expectations or understanding of the triage and intake process	0	11	6
Clients feel comfortable being open and honest in their	0	5	13
Triage and intake is accessible for non- English	0	2	12
The triage/intake process is able to meet the diverse cultural needs and preferences of the Monterey County	0	6	11

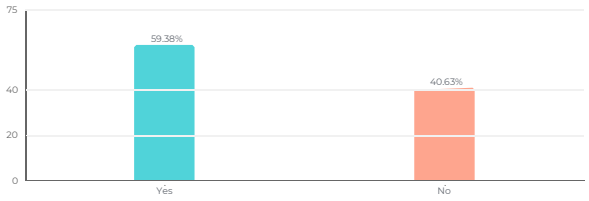
	ST RONG LY AG
Total	**21**

	ST RONG LY DISAG REE	DISAG REE	AG REE
I can easily and reliably share necessary client information with providers outside of my organization or department	4 (20.00%)	9 (45.00%)	7 (35.00%)
Total	**5 (3.57%)**	**48 (34.29%)**	**66**
I am able to accurately identify a client's mental health condition based on MCBH/ACCESS	5		
I spend too much time on screening	2		
Clients have appropriate expectations or understanding of the triage and intake process	3		
Clients feel comfortable being open and honest in their	2		
Triage and intake is accessible for non- English	6		
The triage/intake process is able to meet the diverse cultural needs and preferences of the Monterey County	3		
I can easily and reliably share necessary client information with providers outside of my organization	0		

QUESTION 06 | YES O R NO

Do you provide clients with referrals as part of your job duties?

Answered: **32** Skipped: **0**

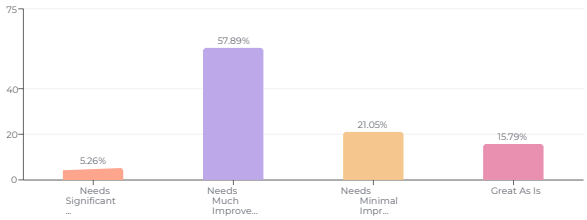


ANSWER CHOICES	RESPONSES	RESPONSE PERCENT AG E
Yes	19	59.38%
No	13	40.63%

QUEST ION 07 | O PINIO N SCALE

On a scale of 1-4, how would you rate referral procedures overall?

Answered: **19** Skipped:



ANSWER	RESPONSES	RESPONSE PERCENT AG
Needs Significant	1	5.26
Needs Much	11	57.89
Needs Minimal Improvement	4	21.05%
Great As Is	3	15.79%

QUEST ION 08 | MATRIX

Below are some characteristics of referral procedures for mental and behavioral health services. On a scale of 1-4, how would you generally

Answered: **19** Skipped:

	NEEDS SIG NIFICANT IMPROVEMENT	NEEDS SOME IMPROVEMENT	NEEDS MINIMAL IMPROVEMENT
Your familiarity with available resources or ability to access a	2	7	9
Community resource information is up-to- date (contact information, services provided,	4	11	3
Ability of clients to get in contact and register with the referred services	5	9	4
Availability of culturally aligned and language accessible resources	2 (10.53%)	8 (42.11%)	6 (31.58%)
Ease of ensuring that clients are eligible for the services referred to	3 (15.79%)	8 (42.11%)	6 (31.58%)
Availability of resources for most needs	8 (42.11%)	7 (36.84%)	3 (15.79%)

	NEEDS SIG NIFICANT IMPROVEMENT	NEEDS SOME IMPROVEMENT	NEEDS MINIMAL IMPROVEMENT
Ease of sharing information between your agency or department and a referral agency (i.e. the client experiences a more seamless transition because the referral	4	8 (42.11%)	6
Total	**28**	**58**	**37**

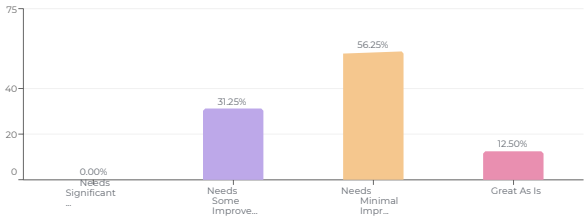
	G REAT AS
Your familiarity with available resources or ability to access a	1 (5.26%)
Community resource information is up-to- date (contact information, services provided,	1 (5.26%)
Ability of clients to get in contact and register with the referred services	1 (5.26%)
Availability of culturally aligned and language	3
Ease of ensuring that clients are eligible for the services referred	2
Availability of resources for most needs	1 (5.26%)

	G REAT AS
Ease of sharing information between your agency or department and a referral agency (i.e. the client experiences a more seamless transition because the referral	1 (5.26%)
Total	**10**

QUESTION 10 | OPINION SCALE

On a scale of 1-4, how would you rate Monterey County's current offering of mental health and behavioral health services?

Answered: **32** Skipped: **0**

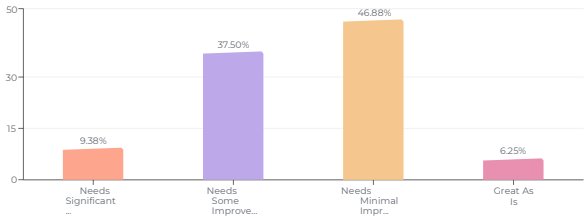


ANSWER CHOICES	RESPONSES	RESPONSE PERCENTAGE
Needs Significant Improvement	0	0.00%
Needs Some Improvement	10	31.25%
Needs Minimal Improvement	18	56.25%
Great As Is	4	12.50%

QUESTION 11 | OPINION SCALE

On a scale of 1-4, how would you rate Monterey County's offering of services and programs' current ability to meet the needs of the community in Monterey County?

Answered: **32** Skipped: **0**



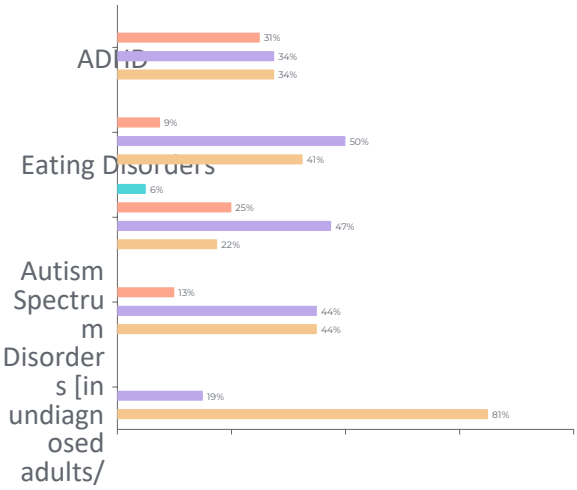
ANSWER CHOICES	RESPONSES	RESPONSE PERCENTAGE
Needs Significant Improvement	3	9.38%
Needs Some Improvement	12	37.50%
Needs Minimal Improvement	15	46.88%
Great As Is	2	6.25%

FEEDBACK ON THE SCREENING TOOL DESIG 4

QUESTION 13 | MATRIX

The screening tool we are creating will screen people age 16 and older for the following conditions: Anxiety, Depression, Bipolar Disorders, Post Traumatic Stress Disorder (PTSD), Psychosis/Schizophrenia, and Substance Use Disorders. Below is a list of other mental health conditions we are also considering screening for. Please rate how important you think it

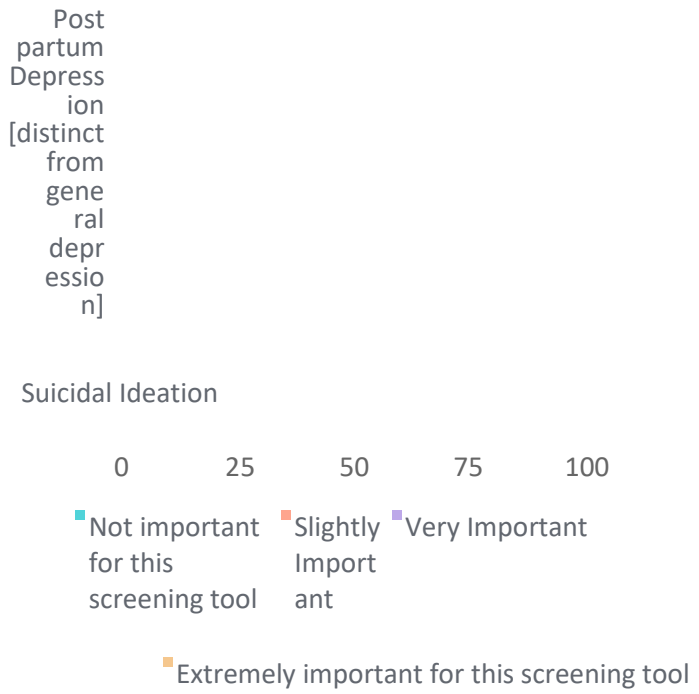
Answered: **32** Skipped:



	NOT IMPORTANT FOR THIS SCREENING TOOL	SLIGHTLY IMPORTANT	VERY IMPORTANT
ADHD	0 (0.00%)	10 (31.25%)	11 (34.38%)
Eating Disorders	0 (0.00%)	3 (9.38%)	16 (50.00%)
Autism Spectrum Disorders [in undiagnosed adults/ young adults]	2 (6.25%)	8 (25.00%)	15 (46.88%)
Postpartum Depression [distinct from general depression]	0 (0.00%)	4 (12.50%)	14 (43.75%)
Suicidal Ideation	0 (0.00%)	0 (0.00%)	6 (18.75%)
Total	**2 (1.25%)**	**25 (15.63%)**	**62 (38.75%)**

	EXTREMELY IMPORTANT FOR THIS SCREENING TOOL
ADHD	11
Eating	13
Autism Spectrum Disorders [in undiagnosed	7
Postpartum Depression [distinct from general	14
Suicidal	26
Total	**71**

young adu...


Post partum Depression [distinct from general depression]
Suicidal Ideation
0
25
50
75
100
Not important for this screening tool
Slightly Important
Very Important
Extremely important for this screening tool

FEEDBACK ON T HE SCREENING T OOL DESIG N

QUEST ION 15 | MULTIPLE CHO ICE

Below is a list of factors that impact behavioral health which we are also considering including in the screening tool. Please select any factors you believe are important to include in this screening tool as it relates to addressing a client's mental health needs.

You may select "Other" and type in any additional factors not already listed.

Answered: **32** Skipped: **0**

ANSWER	RESPONSES	RESPONSE PERCENT AG
Physical Health Status (i.e. chronic pain or other medical	27	10.71%
Housing	26	10.32%
Access to	18	7.14%
History of	32	12.70
Insurance/Medi-Cal	23	9.13%
Food	27	10.71%
Employment	17	6.75
Extent of Social	23	9.13%
Sleep	25	9.92
Immigration	13	5.16%
History of	18	7.14%
Othe	3	1.19%

FEEDBACK ON T HE SCREENING T OOL DESIG N

QUEST ION 16 | RANK O RDER

We are considering different ways you could share this online screening tool with beneficiaries who may benefit from it.
Please rank the following options from 1-5 with 1 = The option you would use the most and 5 = The

Answered: **32** Skipped:

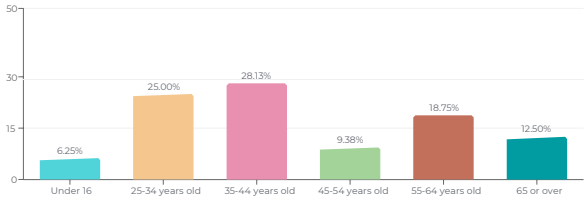
ANSWER	AVERAG	RESPONSE PERCENT AG
Send client a text from your work phone 21.60 or computer with the link to the screening tool		22.50
Have client text SCREENING to a number, 19.00 and client receives a text with a link to		19.79
Send or display a QR code for client to scan	16.0	16.67
Use email or other online messaging service to share access to the screening tool	20.8	21.67%
Hand out or display physical flyer, brochure or other	18.6	19.38

DEMOG RAPHIC QUEST 5

QUEST ION 17 | MULTIPLE CHO ICE

What is your age

Answered: **32** Skipped:



ANSWER CHOICES	RESPONSES	RESPONSE PERCENT AG E
Under 16	2	6.25%
25-34 years old	8	25.00%
35-44 years old	9	28.13%
45-54 years old	3	9.38%
55-64 years old	6	18.75%
65 or over	4	12.50%

DEMOG RAPHIC QUEST IONS

QUEST ION 18 | MULTIPLE CHO ICE

What is your

Answered: **32** Skipped:

ANSWER CHOICES	RESPONSES	RESPONSE PERCENT AG E
Woman	24	75.00%
Man	8	25.00%
Non-binary	0	0.00%
Other	0	0.00%

DEMOG RAPHIC QUEST IONS

QUEST ION 21 | MULTIPLE CHO ICE

What is your job

Answered: **32** Skipped:

ANSWER	RESPONSES	RESPONSE PERCENT AG
Individual contributor, Administrative, Entry-level	12	37.50
Team lead, Manager,	12	37.50
Senior-level	8	25.00

QUEST ION 22 | CO NSENT/AGREEMENT

You said that you do NOT work for Monterey County, so you will have a chance to win one of fifteen $50 Mastercard gift cards at the end of this survey. Please remember to tell the truth. Your answers are anonymous and your name or contact information will NOT be shared with Monterey County or any other government agency.

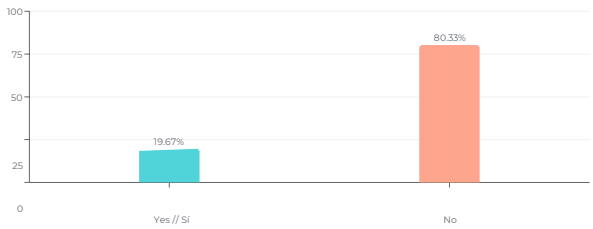
Dijo que no trabaja para el Condado de Monterey

ANSWER	RESPONSES	RESPONSE PERCENT AG
Agre	61	100.00

QUEST ION 23 | YES O R NO

Have you (or an adult that you are responsible for) ever talked to a Monterey County Behavioral Health (MCBH) or ACCESS representative to request services?

¿Alguna vez usted (o un adulto/a del cual usted es responsable) ha hablado con un

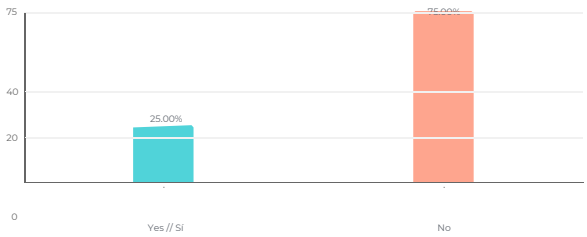


ANSWER	RESPONSES	RESPONSE PERCENT AG
Yes //	12	19.67
N	4	80.33

QUEST ION 24 | YES O R NO

Do you (or an adult that you are responsible for) currently have a Monterey County Behavioral Health case manager?

¿Tiene usted (o un adulto/a del cual usted es responsable) un administrador de caso de la



ANSWER	RESPONSES	RESPONSE PERCENT AG
Yes //	3	25.00
N	9	75.00

QUEST ION 25 | MULTIPLE CHO ICE

What was your first step to seeking MCBH services? (Select all that apply)

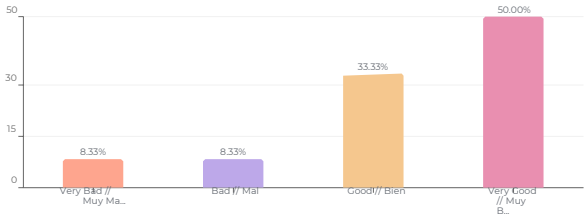
¿Cuál fue su primer paso para pedir servicios con la División de Salud Mental del Condado de

toll- 4 free line. // Llamé una ubicación de		
I visited an ACCESS location in person. // 1 Visité una ubicación de ACCESO en		6.67
I was referred to MCBH services by a social worker, therapist, medical staff, school staff, or other professional. // Una trabajadora social, terapeuta, personal médico, personal de la escuela, u otro profesional me refirió a	7	46.67
I was referred to MCBH services by a friend or family member. // Un amigo, miembro de la familia, u otro ser querido me refirió a servicios de la División de Salud	1	6.67
Other // Algo	2	13.33%

QUEST ION 26 | O PINIO N SCALE

How would you rate your experience with Monterey County Behavioral Health screening? (Screening involves the first 1-3 conversations you ever had with ACCESS or MCBH staff where you asked for help and talked about what supports you may need and qualify for)

¿Cómo calificaría su experiencia con el proceso



ANSWER	RESPONSES	RESPONSE PERCENT AG
Very Bad // Muy	1	8.33
Bad //	1	8.33
Good //	4	33.33
Very Good // Muy	6	50.00

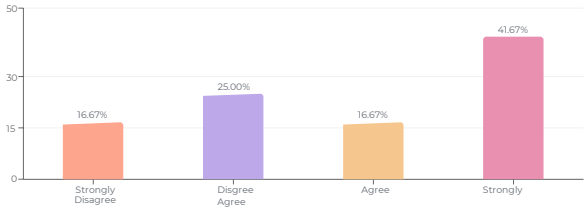
SCREENING // 6

QUEST ION 27 | O PINIO N SCALE

It was easy to get in contact with ACCESS/MCBH staff the first time I requested services.

Fue fácil ponerse en contacto con el personal de ACCESO/la División de Salud Mental la primera vez que solicité servicios.

Answered: **12** Skipped: **0**



ANSWER CHOICES	RESPONSES	RESPONSE PERCENT AG E
Strongly Disagree	2	16.67%
Disgree	3	25.00%
Agree	2	16.67%
Strongly Agree	5	41.67%

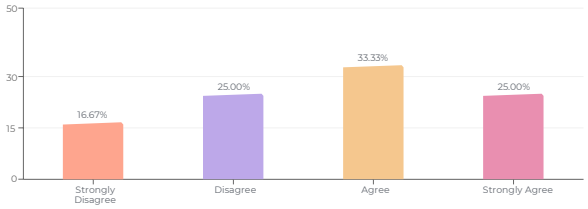
SCREENING // EVALUACIÓN

QUEST ION 28 | O PINIO N SCALE

The amount of time it took to complete my screening or intake was reasonable.

El tiempo que tomó completar mi evaluación o admisión fue razonable.

Answered: **12** Skipped: **0**



ANSWER CHOICES	RESPONSES	RESPONSE PERCENT AG E
Strongly Disagree	2	16.67%
Disagree	3	25.00%
Agree	4	33.33%
Strongly Agree	3	25.00%

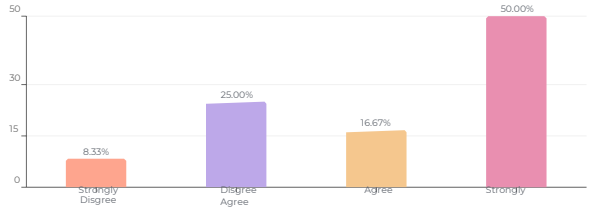
SCREENING // EVALUACIÓN

QUEST ION 29 | O PINIO N SCALE

I clearly understood the screening process and the questions asked of me.

Entendí claramente el proceso de evaluación y las preguntas que me hicieron.

Answered: **12** Skipped: **0**



ANSWER CHOICES	RESPONSES	RESPONSE PERCENT AG E
Strongly Disgree	1	8.33%
Disgree	3	25.00%
Agree	2	16.67%
Strongly Agree	6	50.00%

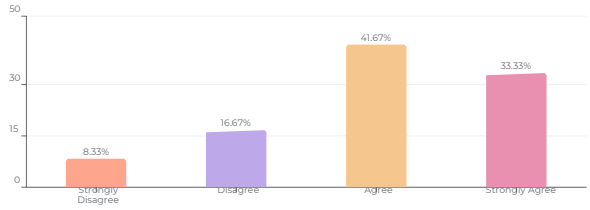
SCREENING // EVALUACIÓN

QUEST ION 30 | O PINIO N SCALE

I felt comfortable sharing personal information with the person screening me.

Me sentí cómodo compartiendo información personal con la persona que me evaluó.

Answered: **12** Skipped: **0**



ANSWER CHOICES	RESPONSES	RESPONSE PERCENT AG E
Strongly Disagree	1	8.33%
Disagree	2	16.67%
Agree	5	41.67%
Strongly Agree	4	33.33%

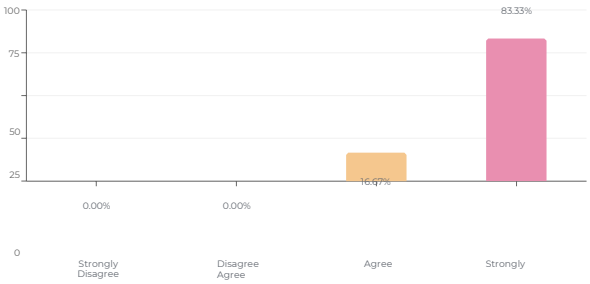
SCREENING // EVALUACIÓN

QUEST ION 31 | O PINIO N SCALE

I could talk to MCBH or ACCESS staff in my preferred language.

Podría hablar con el personal de ACCESO o la División de Salud Mental en mi idioma preferido.

Answered: **12** Skipped: **0**



ANSWER CHOICES	RESPONSES	RESPONSE PERCENT AG E
Strongly Disagree	0	0.00%
Disagree	0	0.00%
Agree	2	16.67%
Strongly Agree	10	83.33%

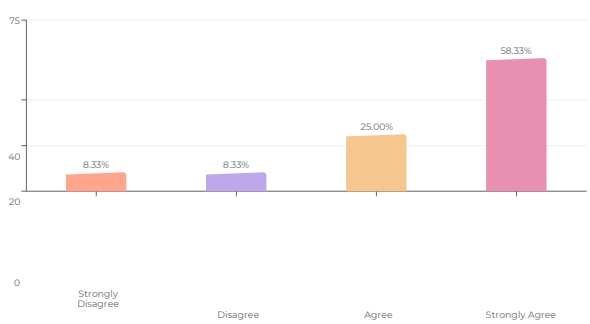
SCREENING // EVALUACIÓN

QUEST ION 32 | O PINIO N SCALE

I agreed with the results and suggestions provided to me at the end of my screening.

Estuve de acuerdo con los resultados y las sugerencias que se me proporcionaron al final de mi evaluación.

Answered: **12** Skipped: **0**



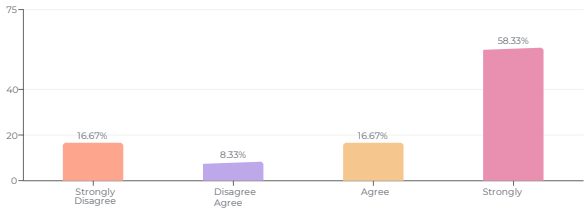
ANSWER CHOICES	RESPONSES	RESPONSE PERCENT AG E
Strongly Disagree	1	8.33%
Disagree	1	8.33%
Agree	3	25.00%
Strongly Agree	7	58.33%

QUEST ION 33 | O PINIO N SCALE

I was connected to the type of services I was hoping for.

Yo estaba conectado al tipo de servicios que esperaba.

Answered: **12** Skipped: **0**



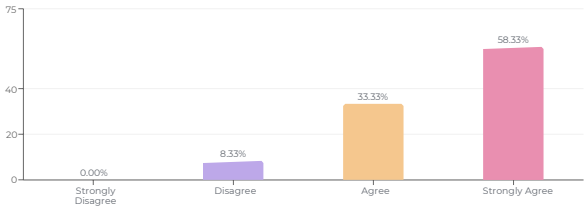
ANSWER CHOICES	RESPONSES	RESPONSE PERCENT AG E
Strongly Disagree	2	16.67%
Disagree	1	8.33%
Agree	2	16.67%
Strongly Agree	7	58.33%

QUEST ION 34 | O PINIO N SCALE

The address, contact information, and/or hours of service were correct for the referral I received.

La dirección, la información de contacto y/o las horas de servicio eran correctas para la referencia que recibí.

Answered: **12** Skipped: **0**



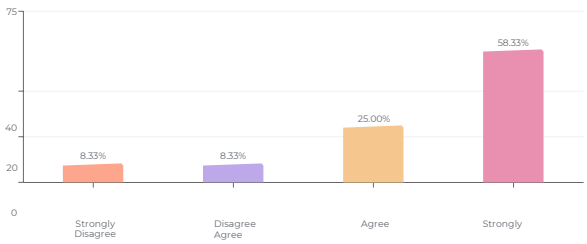
ANSWER CHOICES	RESPONSES	RESPONSE PERCENT AG E
Strongly Disagree	0	0.00%
Disagree	1	8.33%
Agree	4	33.33%
Strongly Agree	7	58.33%

QUEST ION 35 | O PINIO N SCALE

I could easily get in contact with the organization I was referred to.

Fácilmente podría ponerme en contacto con la organización a la que me recomendaron.

Answered: **12** Skipped: **0**



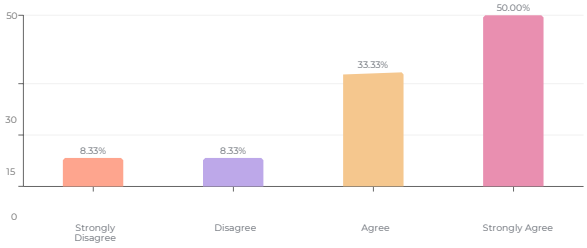
ANSWER CHOICES	RESPONSES	RESPONSE PERCENT AG E
Strongly Disagree	1	8.33%
Disagree	1	8.33%
Agree	3	25.00%
Strongly Agree	7	58.33%

QUEST ION 36 | O PINIO N SCALE

The services I was referred to matched my cultural preferences or reflected my identity.

Los servicios a los que me refieron coinciden con mis preferencias culturales o reflejan mi identidad.

Answered: **12** Skipped: **0**



ANSWER CHOICES	RESPONSES	RESPONSE PERCENT AG E
Strongly Disagree	1	8.33%
Disagree	1	8.33%
Agree	4	33.33%
Strongly Agree	6	50.00%

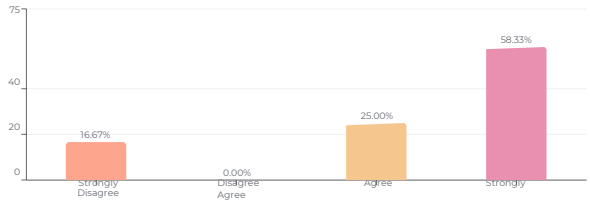
REFERRALS // REFERENCIAS

QUEST ION 37 | O PINIO N SCALE

I was eligible for the services that I was referred to.

Yo era elegible para los servicios a los que me remitieron.

Answered: **12** Skipped: **0**



ANSWER CHOICES	RESPONSES	RESPONSE PERCENT AG E
Strongly Disagree	2	16.67%
Disagree	0	0.00%
Agree	3	25.00%
Strongly Agree	7	58.33%

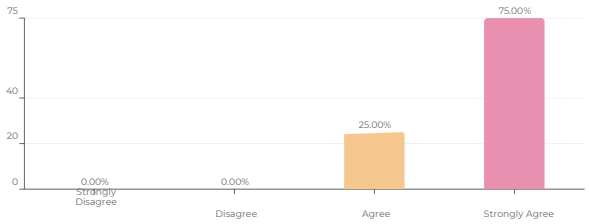
REFERRALS // REFERENCIAS

QUEST ION 38 | O PINIO N SCALE

The services I was referred to were available in my preferred language.

Los servicios a los que me refirieron estaban disponibles en mi idioma preferido.

Answered: **12** Skipped: **0**



ANSWER CHOICES	RESPONSES	RESPONSE PERCENT AG E
Strongly Disagree	0	0.00%
Disagree	0	0.00%
Agree	3	25.00%
Strongly Agree	9	75.00%

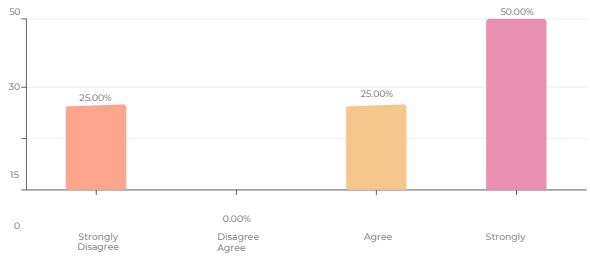
REFERRALS // REFERENCIAS

QUEST ION 39 | O PINIO N SCALE

I could easily access the services I was referred to (for example, you could find transportation to get there, you did not have to drive too far, or there were online options, etc.)

Podía acceder fácilmente a los servicios a los que me referían (por ejemplo, podía encontrar transporte para llegar allí, no tenía que conducir demasiado, o había opciones en línea, etc.)

Answered: **12** Skipped: **0**



ANSWER CHOICES	RESPONSES	RESPONSE PERCENT AG E
Strongly Disagree	3	25.00%
Disagree	0	0.00%
Agree	3	25.00%
Strongly Agree	6	50.00%

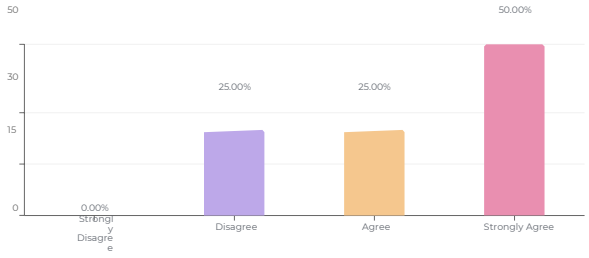
REFERRALS // REFERENCIAS

QUEST ION 40 | O PINIO N SCALE

Any questions or concerns I had with the referral process were answered in a reasonable amount of time.

Cualquier pregunta o inquietud que tuve con el proceso de referencia fue respondida en un período de tiempo razonable.

Answered: **12** Skipped: **0**

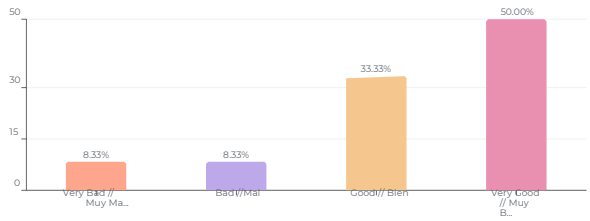


ANSWER CHOICES	RESPONSES	RESPONSE PERCENT AG E
Strongly Disagree	0	0.00%
Disagree	3	25.00%
Agree	3	25.00%
Strongly Agree	6	50.00%

QUESTION 41 | RATING

On a scale of 1-4, how would you rate MCBH overall?

En una escala del 1 al 4, ¿cómo calificaría a la

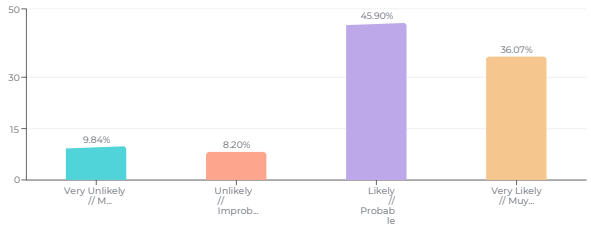


ANSWER	RESPONSES	RESPONSE PERCENT AG
Very Bad // Muy	1	8.33
Bad	1	8.33
Good //	4	33.33
Very Good // Muy	6	50.00

QUESTION 43 | MULTIPLE CHOICE

We are creating a mental health quiz that you can take on your phone, computer, or other mobile device. It will let you know what mental health challenges you may have and let you know about online and local resources based on your results. It would take less than 15 minutes to complete and you would have the choice to send your results to Monterey County Behavioral Health, a different provider, or keep your results private. Please rate how likely you are to take this quiz.

Estamos creando un cuestionario para salud mental que puede completar en su celular

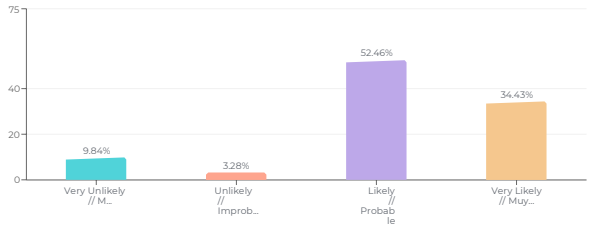


ANSWER CHOICES	RESPONSES	RESPONSE PERCENT AG E
Very Unlikely // Muy improbable	6	9.84%
Unlikely // Improbable	5	8.20%
Likely // Probable	28	45.90%
Very Likely // Muy probable	22	36.07%

QUESTION 44 | MULTIPLE CHOICE

How likely are you to recommend this quiz to a friend, family member, or other loved one?

¿Qué probabilidad hay de que recomiende esta cuestonario a un amigo, familiar u otro ser querido?

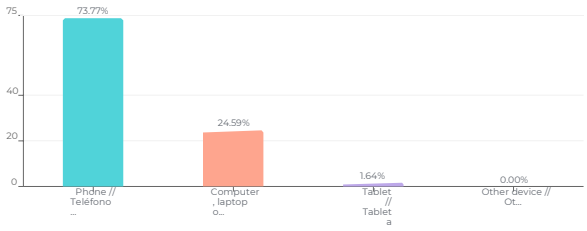


ANSWER CHOICES	RESPONSES	RESPONSE PERCENT AG E
Very Unlikely // Muy improbable	6	9.84%
Unlikely // Improbable	2	3.28%
Likely // Probable	32	52.46%
Very Likely // Muy probable	21	34.43%

QUEST ION 45 | MULTIPLE CHO ICE

What type of device do you use the most for your online activities?

¿Qué tipo de aparato utiliza más para sus actividades

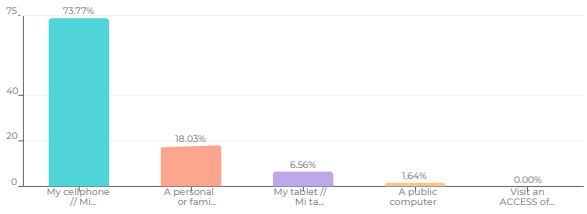


ANSWER CHOICES	RESPONSES	RESPONSE PERCENT AG E
Phone // Teléfono móvil	45	73.77%
Computer, laptop or desktop // Computadora, portátil o sobremesa	15	24.59%
Tablet // Tableta	1	1.64%
Other device // Otro aparato de tecnología	0	0.00%

QUEST ION 46 | MULTIPLE CHO ICE

If this quiz became available tomorrow, what device would you most likely use to take it?

Si este cuestionario estuviera disponible mañana,



ANSWER CHOICES	RESPONSES	RESPONSE PERCENT AG E
My cellphone // Mi teléfono móvil	45	73.77%
A personal or family computer, laptop or desktop // Una computadora, portátil o sobremesa personal o familiar	11	18.03%
My tablet // Mi tableta	4	6.56%
A public computer such as at the library or school // Una computadora pública como en la biblioteca o la escuela	1	1.64%
Visit an ACCESS office and take it on a private computer in their lobby (Visitaría una oficina de ACCESO y lo tomaría en una computadora privada en su vestíbulo)	0	0.00%

QUEST ION 47 | RANK O RDER

We are thinking about different ways someone in the community can find out about the quiz. Please rank these options with 1 = The option you would use the most and 5 = The option you would use the least.

Estamos pensando en diferentes formas en que

ANSWER	AVERAG	RESPONSE PERCENT AG
An MCBH staff member texts you with a 40.20 link to the quiz. // Un miembro del equipo de la División de Salud Mental le envía un mensaje de texto con un hiperenlace del		21.97%
You text SCREENING to a specific phone 43.20 number and you receive a text with a link to the quiz. // Ud. envía un texto con el mensage SCREENING a un número y recibe un mensaje de		23.61%
You scan a QR code using your phone or 35.40 other device. // Ud. escanea un código		19.34
You receive an email with a link to the 36.0 0 quiz. // Recibe un correo		19.67
You see or receive a physical flyer, 28.20 brochure or other marketing material about the quiz. // Vee o recibe un folleto u otro material		15.41%

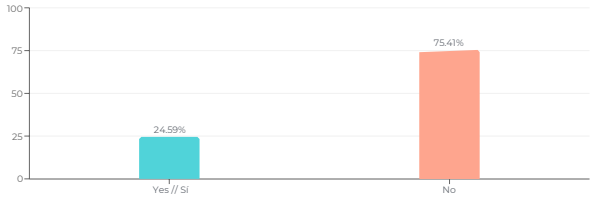
PLEASE SELECT IF YOU WOULD USE T HESE OPT IONAL FEAT URES OR 7

QUEST ION 48 | YES O R NO

Share my quiz results with family and friends.

Comparte mis resultados de este cuestionario con mis familiares o amigos.

Answered: **61** Skipped: **0**



ANSWER	RESPONSES	RESPONSE PERCENT AG
Yes //	15	24.59
N	4	75.41

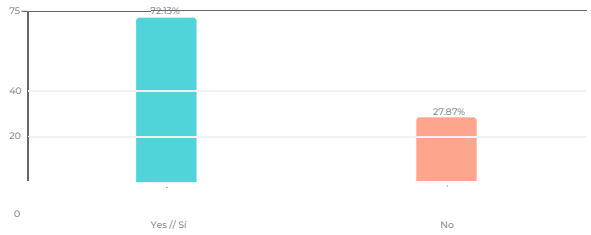
PLEASE SELECT IF YOU WOULD USE T HESE OPT IONAL FEAT URES OR N...

QUEST ION 49 | YES O R NO

Forward quiz results to a mental health provider.

Comparte resultados de este cuestionario a un doctor o otra profesional de salud mental.

Answered: **61** Skipped: **0**



ANSWER	RESPONSES	RESPONSE PERCENT AG
Yes //	4	72.13%
N	17	27.87

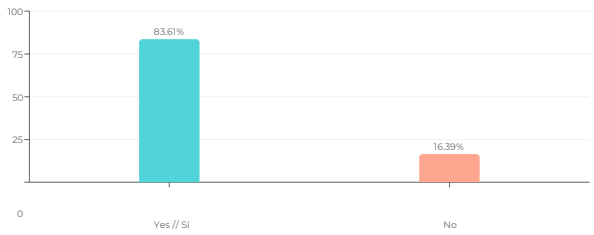
PLEASE SELECT IF YOU WOULD USE T HESE OPT IONAL FEAT URES OR N...

QUEST ION 50 | YES O R NO

Look at my past quiz results.

Ver a mis resultados pasados.

Answered: **61** Skipped: **0**



ANSWER	RESPONSES	RESPONSE PERCENT AG
Yes //	51	83.61
N	10	16.39%

PLEASE SELECT IF YOU WOULD USE T HESE OPT IONAL FEAT URES OR N...

QUEST ION 51 | YES O R NO

Receive referrals to online self-help resources in addition to local in-person resources.

Recibe recomendaciones a recursos de esfuerzo personal en línea además de recursos locales en persona.

Answered: **61** Skipped: **0**

ANSWER	RESPONSES	RESPONSE PERCENT AG
Yes //	51	83.61
N	10	16.39%

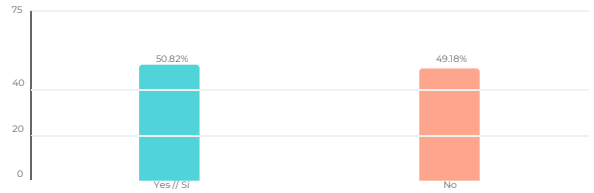
PLEASE SELECT IF YOU WOULD USE T HESE OPT IONAL FEAT URES OR N...

QUEST ION 52 | YES O R NO

Print my quiz results.

Imprime mis resultados del cuestionario.

Answered: **61** Skipped: **0**



ANSWER	RESPONSES	RESPONSE PERCENT AG
Yes //	31	50.82
N	3	49.18

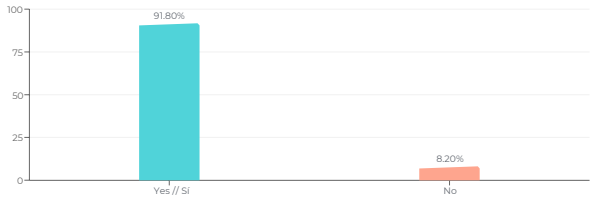
PLEASE SELECT IF YOU WOULD USE T HESE OPT IONAL FEAT URES OR N...

QUEST ION 53 | YES O R NO

View County resources and services that accept my insurance.

Ver recursos y servicios en el Condado de Monterey que aceptan mi seguro médico.

Answered: **61** Skipped: **0**



ANSWER	RESPONSES	RESPONSE PERCENT AG
Yes //	56	91.80
N	5	8.20

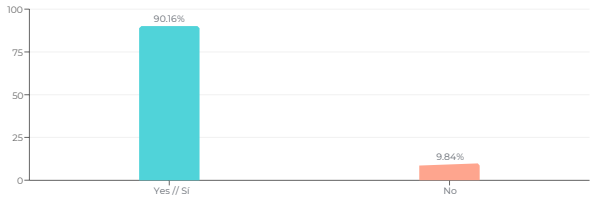
PLEASE SELECT IF YOU WOULD USE T HESE OPT IONAL FEAT URES OR N...

QUEST ION 54 | YES O R NO

View County resources and services based on my location.

Ver recursos y servicios en el Condado de Monterey según de mi locación.

Answered: **61** Skipped: **0**



ANSWER	RESPONSES	RESPONSE PERCENT AG
Yes //	55	90.16
N	6	9.84

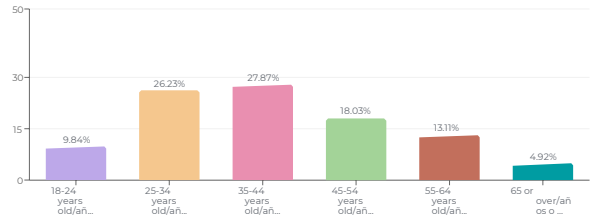
DEMOG RAPHICS // DAT OS DEMOG 7

QUEST ION 56 | MULTIPLE CHO ICE

What is your age range?

¿Cuál es su rango de edad?

Answered: **61** Skipped: **0**



ANSWER CHOICES	RESPONSES	RESPONSE PERCENT AG E
18-24 years old/años	6	9.84%
25-34 years old/años	16	26.23%
35-44 years old/años	17	27.87%
45-54 years old/años	11	18.03%
55-64 years old/años	8	13.11%
65 or over/años o más	3	4.92%

DEMOG RAPHICS // DAT OS DEMOG RÁFICOS

QUEST ION 57 | MULTIPLE CHO ICE

What is your gender?

¿Cuál es su género?

Answered: **61** Skipped: **0**

ANSWER	RESPONSES	RESPONSE PERCENT AG
Woman //	5	88.52
Man //	6	9.84
Non-Binary // No	1	1.64%
Other // Otro	0	0.00

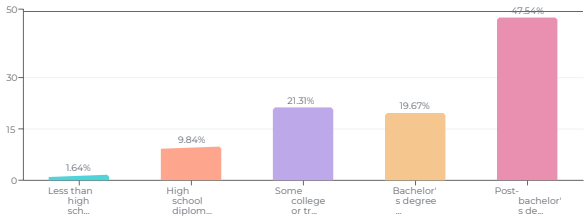
DEMOG RAPHICS // DAT OS DEMOG RÁFICOS

QUEST ION 59 | MULTIPLE CHO ICE

What is your highest level of education?

¿Cual es su nivel más alto de educación?

Answered: **61** Skipped: **0**



ANSWER CHOICES	RESPONSES	RESPONSE PERCENT AG E
Less than high school // Menos de secundaria	1	1.64%
High school diploma or GED // Secundaria	6	9.84%
Some college or trade school // Escuela de oficio o universitaria pero incompleta	13	21.31%
Bachelor's degree // Licenciatura universitaria	12	19.67%
Post-bachelor's degree i.e. master's, doctorate // Maestria o doctorado	29	47.54%

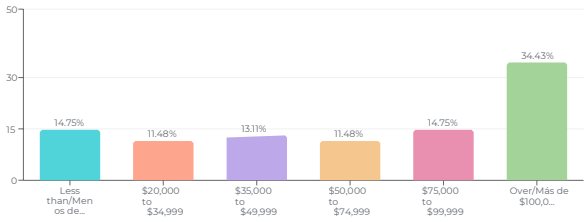
DEMOG RAPHICS // DAT OS DEMOG RÁFICOS

QUEST ION 60 | MULTIPLE CHO ICE

What is your household income level?

¿Cuál es el nivel de ingresos de su hogar?

Answered: **61** Skipped: **0**



ANSWER CHOICES	RESPONSES	RESPONSE PERCENT AG E
Less than/Menos de $20,000	9	14.75%
$20,000 to $34,999	7	11.48%
$35,000 to $49,999	8	13.11%
$50,000 to $74,999	7	11.48%
$75,000 to $99,999	9	14.75%
Over/Más de $100,000	21	34.43%

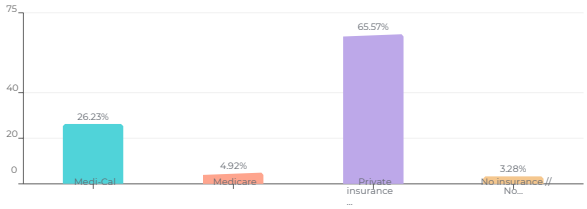
DEMOG RAPHICS // DAT OS DEMOG RÁFICOS

QUEST ION 61 | MULTIPLE CHO ICE

Do you have health insurance? (Check all that apply)

¿Tienes seguro médico? (Marque todo lo que corresponda)

Answered: **61** Skipped: **0**



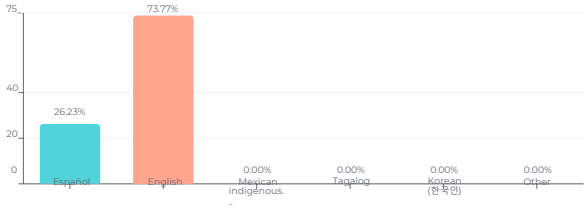
DEMOG RAPHICS // DAT OS DEMOG RÁFICOS

QUEST ION 62 | MULTIPLE CHO ICE

What language do you speak most at home?

¿Qué idioma hablas más en casa?

Answered: **61** Skipped: **0**



ANSWER CHOICES	RESPONSES	RESPONSE PERCENT AG E
Medi-Cal	16	26.23%
Medicare	3	4.92%
Private insurance // Seguro médico privada	40	65.57%
No insurance // No seguro médico	2	3.28%

ANSWER CHOICES	RESPONSES	RESPONSE PERCENT AG E
Español	16	26.23%
English	45	73.77%
Mexican indigenous language or dialect // Lengua o dialecto indígena mexicano como Mixteco, Triqui, o Chatino	0	0.00%
Tagalog	0	0.00%
Korean (한국인)	0	0.00%
Other	0	0.00%

Appendix F: Functional Design Document

CredibleMind

4.0 Functional Design Document

Introduction

MAY 11, 2022

The following pages include summaries and required deliverables for 4.0-4.4 Functional Design Document for the Help@Hand screening application project. All parts are listed in the Table of Contents below.

Table of Contents

Additional Appendices (Not attached to this document)

C. Draft of screening questions in English and Spanish.pdf
D. Screener components.xlsx
E. Help at Hand Screening May User Test Mock Ups.pdf

CredibleMind

Design Document

Introduction to Design Processes

After the completion of the Research phase, the CredibleMind Technology team initiated the Design phase by developing user personas (pages 6-7) and user journeys (Appendix A in this document) for the screening application. These elements reflected the need for a responsive design that adapts easily for anonymous users so that the application can be used by infrequent users without training. The screening answers and results cannot be associated through personally identifiable information (PII). The contract calls for the experience to be offered in English and Spanish. The business logic and content maintenance over time needs to be highly configurable for each county.

The following user experiences will be achieved through an anonymous community user profile design, a signed-in community user profile design, an anonymous clinical user design, and an "At the Clinic Mode". The information architecture will be managed through a content management system design for counties, screening tools, referral information, and local resources. The content management system design includes localization for the display of English and Spanish languages.

Community Users

First, user profile designs for people taking the screener will be designed for both anonymous and signed-in users. A user may take the screener as many times as they like and will be issued an anonymous *Access Code*[1] for each result. The user will have the option to share the *Access Code* with a provider or other professional. The shared *Access Code* will need to be provided along with the county's URL and the person's identifiable information via a secure method such as calling the clinic or using a patient portal. The *Access Code* alone will lead to completely anonymous results. Alternatively, the signed-in user will be able to view prior screener results in their user profile history and receive results to the email address associated with their user account. If a signed-in user chooses to share their results via an *Access Code*, the results will also be anonymous to protect privacy and confidentiality. Results will emphasize a referral opportunity if the site is not set to At the Clinic Mode.

Providers

A clinical user or provider receiving an *Access Code* from a member of the community will need to know about the county's screening application or need a URL from the user. Training materials will be developed and provided to clinical users before the launch of the screener. The clinical user can then type in the *Access Code* at the URL and view the anonymous results along with the full set of item responses and information on the validated scales that were selected to be included in the screener questions. Downloading a full PDF of all details in a clinically acceptable format is an option. The clinical user may also choose to view "online only" and return in the future assuming that the clinical user keeps the *Access Code* and the person's identity in a secure place. Providers are not required to create an account or authenticate themselves as a member of the therapeutic community. As such, the features for

[1] We are aware that the word "Access" is also used in Monterey County to refer to MCBH's ACCESS to Treatment Clinics. The term "access code" tested well in initial user testing sessions. We plan to use this code with ACCESS clinics and other providers as long as it is not a point of confusion.

providers will be designed as transparent to community users. The value of this solution will be in the easy adoption and utilization of the screening tool.

At the Clinic Mode

A provider may choose to administer the screening to a client from within an office or clinical setting. In this case, it may not be appropriate to show a referral option, particularly to the location where the client is presently at. The At the Clinic Mode can be set at any time and will remain set for the device until deselected. The community user in a clinic who takes a screening will see a message to return the device upon completion. An option to clear results will be included.

Information Architecture

The following information will be structured into the content management database for English and Spanish languages. Many of the following record types have matured over time.

1. **Client**—each county will have its own CredibleMind client record and have a unique configuration with URL, main menu item, main page customization, and branding.
2. **Assessment**—the Help@Hand screening project will use one assessment record.
3. **Assessment results**—the Help@Hand screening project will have many assessment result records for each of the conditions as well as acuity levels for each condition.
4. **Organizations, Services, Locations**—each county will have several organizations, and each organization can have multiple services that are offered at multiple locations. This information will be used for primary referral and additional local service referral within the results of the screening tool.
5. **Topics**, **Audiences, focus Tags**—each county's organizations and services will have certain attributes that a user may view or filter. Responses to demographic questions may identify the user as being a member of a certain audience such as being in a certain age group or having a certain focus tag such as an insurance type. An organization or service can also be associated with a mental health or wellbeing topic.
6. **Site Copy**, **page Intros**—all page-level features include page copy that is structured for future modification and translation into Spanish.
7. **Self-help resources**—For each of CredibleMind's 240 mental health and wellbeing topics, there are thousands of published videos, podcasts, articles, apps, blog articles, and more available. Each resource is also audience- and focus-tagged for further filtering and presentation within results of the screening tool.
8. **Images** - Organizations, Services, Topics, Assessments and Self-help resources all include images that are managed at the site-wide level.

Upcoming changes to Functional Design Document

As of May 11, 2022, CredibleMind has an unresolved change order request. If approved, this design document will serve as an initial draft and an updated version will be submitted by September 12, 2022.

4.1 Draft of Screening Questions

1. Summary

CredibleMind is able to deliver an initial version of the comprehensive web-based mental health screening application based on known requirements. These known requirements, according to the statement of work, include conditions outlined in the table below and demographic questions that both branch to condition subtypes if relevant to the user and assess social determinants of health.

The full draft of screening questions in English and Spanish can be found as an additional upload in Appendix C. Additional supplementary material to support the screener development can be found as an upload in Appendix D. This table shows a summary of conditions, scales, and number of questions:

Condition	**Scale**	**Minimum # of questions**	**Maximum # of questions**
Depression	Two questions of the 4-item Patient Health Questionnaire (PHQ-4), with branching into the 9-item Patient Health Questionnaire (PHQ-9)	2	9
Anxiety	Two questions of the 4-item Patient Health Questionnaire (PHQ-4), with branching into the 7-item Generalized Anxiety Disorder scale (GAD-7)	2	7
Postpartum depression	EPDS (Edinburgh Postnatal Depression Scale)	0	10
Trauma/PTSD	PC-PTSD-5 (Primary Care PTSD Screen for DSM-5)	1	6
Bipolar and Psychosis	WERCAP (Washington Early Recognition Center Affectivity and Psychosis Screen)	16	28
Substance use disorders	TAPS (Tobacco, Alcohol, Prescription medication, and other Substance use) for users 21-years-old and older	5	31
	CRAFFT (Car, Relax, Alone, Forget, Friends, Trouble) 2.1+N (Nicotine) for users 20-years-old and younger	5	20
Plus 12 demographic questions			
TOTAL for non-pregnant youth		**38**	**82**
TOTAL for non-pregnant adult		**38**	**93**

Use cases that result in different question ranges

- For users at risk of anxiety or depression, there are an additional 5 and 7 questions, respectively.
- For a pregnant youth or adult, there are an additional 10 questions.
- For users who affirm that they have experienced a traumatic event, there are an additional 5 questions.
- For users at risk of bipolar or psychosis, there are an additional 3 and 8 questions, respectively. Additionally, there is 1 supplemental question that asks about substance-induced affective or psychotic symptoms.
- For substance use (21+), there are up to 26 additional questions depending on how many and which substances are being used.
- For substance use (<21), there are up to 15 additional questions depending on how many and which substances are being used.

Upcoming changes to draft of screening questions

As of May 11, 2022, CredibleMind has an unresolved change order request. If approved, the current draft of screening questions will serve as an initial draft and an updated version will be submitted by September 12, 2022.

4.2 Design Sprint

1. User Personas

The following user personas were identified to create the main workflows for the prototype.

Persona Summary	User Role	Technology	Language/ Access	Age Range (16+)	Concern	Result	Method
Applicant on smartphone with Concern, English speaking	Services applicant	SmartPhone Only	English speaker	Young Adult	Anxious, can't focus	Concern with Anxiety	Online
Applicant on smartphone with No Concern, Spanish speaking	Services applicant	SmartPhone Only	Spanish preferred/ only	Adult	Impulsive Behavior	No Concern	Online
Applicant on desktop with Concern, English speaking	Services applicant	Desktop	English speaker	Senior	Depressed	Concern with Depression	Online
Applicant on desktop for someone else, Spanish speaking	Loved One on behalf of End User	Desktop	Spanish preferred/ only	Adult	Not Lucid	Concern with Psychosis	Online
Applicant on desktop for self, hearing impaired	Services applicant	Desktop	Hearing Impaired	Adult	Addiction	Concern with Addiction	Online
Applicant on desktop for someone else, other language	Loved One on behalf of End User	SmartPhone Only	Indigenous oral tradition only	Adult	Grief/ Trauma/ PTSD	Concern with Trauma	Online
Applicant walk-in on iPad for self, English speaking	Admin Assistant sets up End User	Clinic iPad	English speaker	Adult	Substance Use	Concern with Substance Use	In Clinic Walk In
Applicant call-in, admin on desktop, English speaking	Admin Assistant on behalf of End User	Clinic Desktop	Sight Impaired	Adult	Depressed	Concern with Depression	In Clinic Over Phone

Behavioral Health Staff on desktop	Clinical User recipient of Services Application	Desktop	English speaker	Adult	Access to PDF	Downloads PDF	MCBH ACCESS uses MyAvatar from ntst.com (NetSmart)
County Admin on desktop	Admin User of County Site	Desktop	English speaker	Adult	Access to admin tools	Adds or edits resources	Online
Help at Hand Admin	Admin User of All Sites	Desktop	English speaker	Adult	Access to admin tools	Adds or edits users, resources	Online

County Stakeholder	Receives Reporting/ Insights	Desktop	English speaker	Adult	Access to Reports	Views reports	Evaluates Program through reports
Help at Hand Stakeholder	Receives Reporting/ Insights	Desktop	English speaker	Adult	Access to Reports	Views reports	Evaluates Program through reports

2. Onboarding Prototype

The full workflow prototype for user testing is a dynamically updated mockup of screens to help communicate workflow and user experience. CredibleMind uses a software called InVision to design mockups and test out workflows and prototypes. All user personas and workflows are represented with detailed emphasis on feature gaps including referral workflows. Key onboarding features include:

1. A primary call-to-action to start screening in English or Spanish
2. Option to view *Need Help Now* resources
3. Option to view *Frequently Asked Questions*
4. Option to *Sign Up* and *Create an Account*
5. Option to retrieve a prior result anonymously via an Access Code

Onboarding and application prototypes are being dynamically updated. There is a slide deck with screenshots that serves as a record of the user testing version (Appendix E as additional upload). To access the onboarding and application prototypes in responsive screen widths, follow these links:

Desktop: https://crediblemindfeedback602374.invisionapp.com/console/share/NFX4VZUQEWA iPad:

https://crediblemindfeedback602374.invisionapp.com/console/share/YSBJT6F9PQN iPhone: https://crediblemindfeedback602374.invisionapp.com/console/share/PWTDUCQKXE4

3. Application Prototype

Using the same onboarding prototype workflows as above, the application prototype represents a sample of screener questions and the following results scenarios. Please see the live platform for a complete user experience of branching questions.

The following key application and referral process features include:

1. Guidance to user taking Screener for self or on behalf of someone else
2. Branching and adaptive Screener questions including demographics collection
3. User results categorized by levels of concern per result scale segmentation
4. User referral guidance to primary behavioral health agency and also to other local resources
5. Segmentation of referral guidance by age range, insurance type and other factors

6. Prioritization of referral locations by user detected location or specified city
7. Anonymous or signed in user option to share an Access Code to retrieve anonymized results
8. User option to create an account and save results to a user profile
9. Users with account created may have results emailed to them
10. All users may download results

4. Prototype of Ability for Provider to Access User Results

To ensure that providers do not need to be authenticated and credentialed, all provider functionality is offered within the main workflows. Please reference the links above under Onboarding Prototype. Key features include the following:

1. An *At the Clinic* mode uses appropriate prompts to users at the end of a screening
2. *View Clinical Result*s options are offered from the home screen and from specific results
3. Provider can receive an Access Code from a user who has taken the screening and view anonymized results
4. Clinical Results include user item responses and validated scale information
5. Clinical Results PDF may be downloaded for upload into an EHR

5. Live Platform Configuration with Questions

The live working configuration is now available on the CredibleMind platform. It includes features marked "not a feature gap" in the Business Requirements (Appendix A in this document). It also includes the complete draft set of screening questions. Key functionality includes:

1. A primary call-to-action to start screening in English or Spanish
2. Option to view *Need Help Now* resources
3. Option to view *Frequently Asked Questions*
4. Option to *Sign Up* and *Create an Account*
5. Answer screener questions on behalf of self
6. Placeholder questions and results (screener does not represent final

set of questions) To access the live platform configurations, follow these

links:

Test Site in Production Environment: testmonterey.crediblemind.com
Test Site in Staging Environment: cm-staging.netlify.app/?brand=testmonterey

Upcoming changes to prototypes and live platform configuration

As of May 11, 2022, CredibleMind has an unresolved change order request. If approved, the prototypes in this deliverable will serve as initial versions and updated versions will be submitted by September 12, 2022.

4.3 User Testing

1. User Testing Script

The CredibleMind Design team completed five virtual user testing sessions in English with residents from Monterey and neighboring Santa Clara Counties for the first round of user testing. The sessions were conducted from April 28 - May 5, 2022. For this first round, we chose to test the initial workflow, homepage, and results designs. Testing sessions lasted approximately 30 minutes each, and participants were reimbursed with a $25 gift card. Our Design team conducted testing using the script located in this document in Appendix B while showing prototype designs via InVision.

2. Summary of User Testing Findings

All five users found the screening to be of interest and the workflow to work well. The confirmatory findings were as follows:

1. Users appreciated the visual appeal of the initial home page.
2. Users appreciated the option to start the screening process in Spanish (some users were bilingual and non-Spanish speakers also commented on the value of this option).
3. Users confirmed they are generally willing to answer the questions that were posed as representative of the entire screening tool.
4. Users understood the summary of their results displayed by levels of concern. Some showed interest in learning more about the various conditions.
5. Users understood conceptually that in addition to viewing results they could be directed to services and they had an appreciation for the overall concept of being guided to services.

The key findings and mitigations were as follows:

1. **Home page** - Ability to enter an access code confused one user. “Do I need an Access Code to access the screener?”
    a. *Mitigation* - The developed version will have Access Code section text changes for retesting.
2. **Sample question Likert format** - Likert-scale questions appearing in varying orders is more confusing to some users. One commented on the varying order and another commented on the design layout not being as friendly as radio buttons. If validated scales offer flexibility, consistency is preferred. A stakeholder also mentioned that Likert-scales may not resonate for various user groups.
    a. *Mitigation* - Continued research and further testing should reveal the best design going forward.
3. **Sample questions context** - users commented that they desired to know why they are being asked certain demographic questions.
    a. *Mitigation* - The final design includes a plan for better context and

descriptions for retesting.

4. **Referral calls to action** - users were confused by the QR Code option for accessing results. Users asked again what they should share on a call or bring when they walk in.

    a. *Mitigation* - A new design without a QR Code and with better instruction text may focus users on their next steps and can be retested.
5. **Results options** - users prefer to have results emailed to them. The results page was suggested as the primary time to request sign-up vs upon question completion before seeing results.
    a. *Mitigation* - The submit button order should be changed based on this feedback.
6. **Results detail** - users expressed an interest in learning more about each condition and their scores. The results sections may include self-care resources and, based on interest, may be better presented without a collapsed accordion.
    a. *Mitigation* - These options are configurations and can be retested.
7. **Hours and locations** - users like this feature and requested that location be optionally detected vs entered. Users want links to Google Maps. Users also want to have access to a phone number.
    a. *Mitigation* - Development plans to include user location detection and research on Google Map linking are underway. Mockups now include a phone number.

Upcoming changes to user testing

As of May 11, 2022, CredibleMind has an unresolved change order request. If approved, additional testing will be conducted. We plan to conduct user acceptance testing with clinicians as well as usability testing of the workflow on our live platform with English- and Spanish-speaking users. Summary of findings of additional testing and updated scripts in English and Spanish will be submitted by September 12, 2022.

4.4 Refinement and Estimated Completion Time

1. Refinement Process

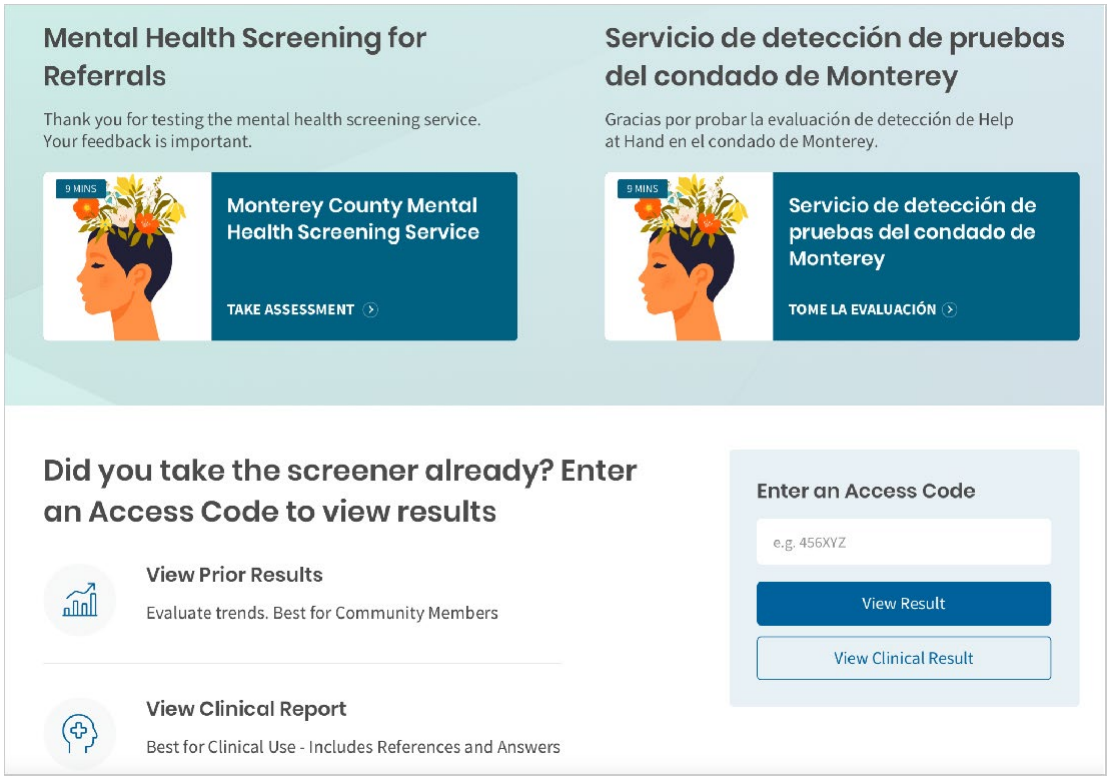
We have been able to refine the screening application based on user testing findings as well as initial feedback from stakeholders to whom we've presented in meetings. Some of these mitigations are outlined above. Here is a full summary of refinements we have made so far:

- We added context to question descriptions so users know why they are being asked certain demographic questions. This change will be made directly on the live platform. Users will see an explanatory subtitle on any

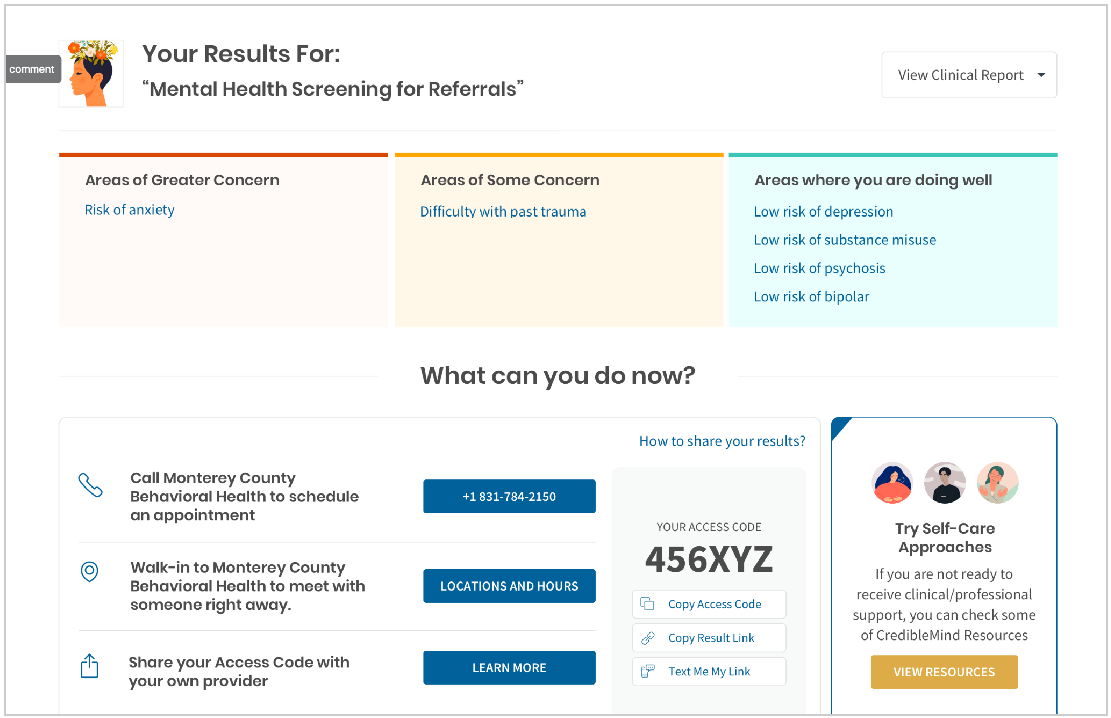
  > **The next set of questions may feel sensitive or strange to answer. We ask these questions to everyone who takes this screener in order to get the most complete picture of your mental health. Please be as honest as possible. As a reminder, your responses are private and anonymous unless you choose to share them.**

  question that requires it.
- The results page was suggested as the primary time to request sign-up vs upon question completion before seeing results. The submit button order will be changed on the live platform based on this feedback.

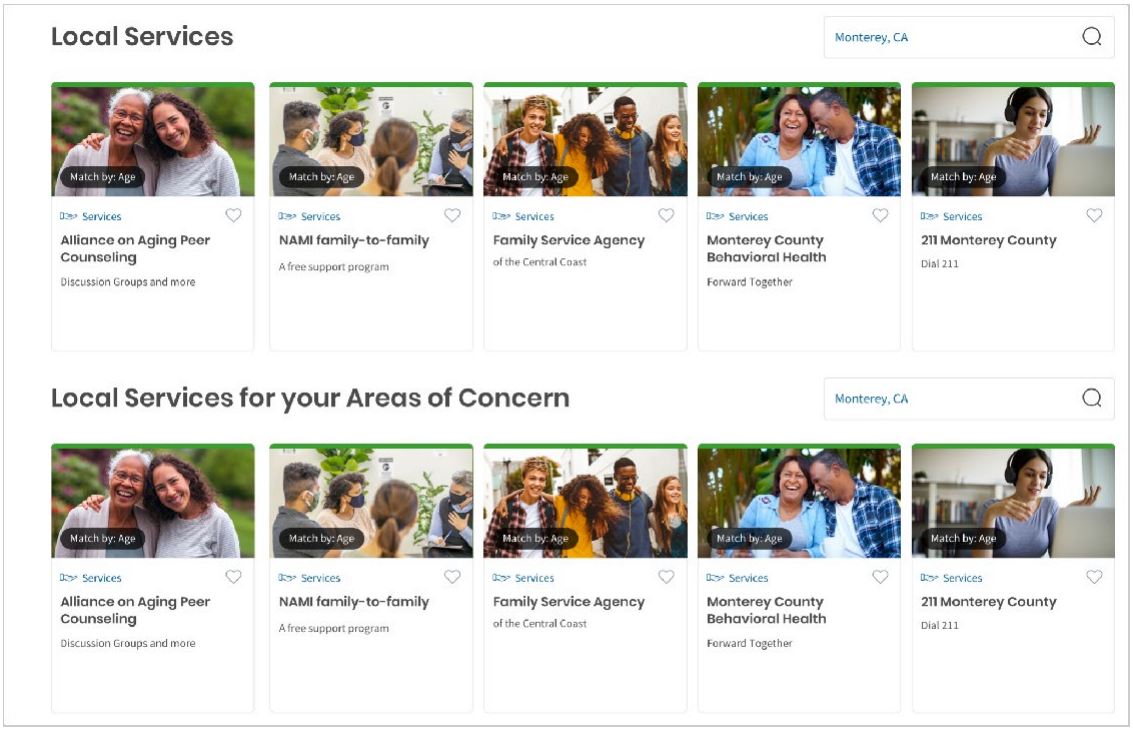
- During testing, users were confused by the option to enter an Access Code on the first view. Text was updated to make it clear that the second section is for prior results.



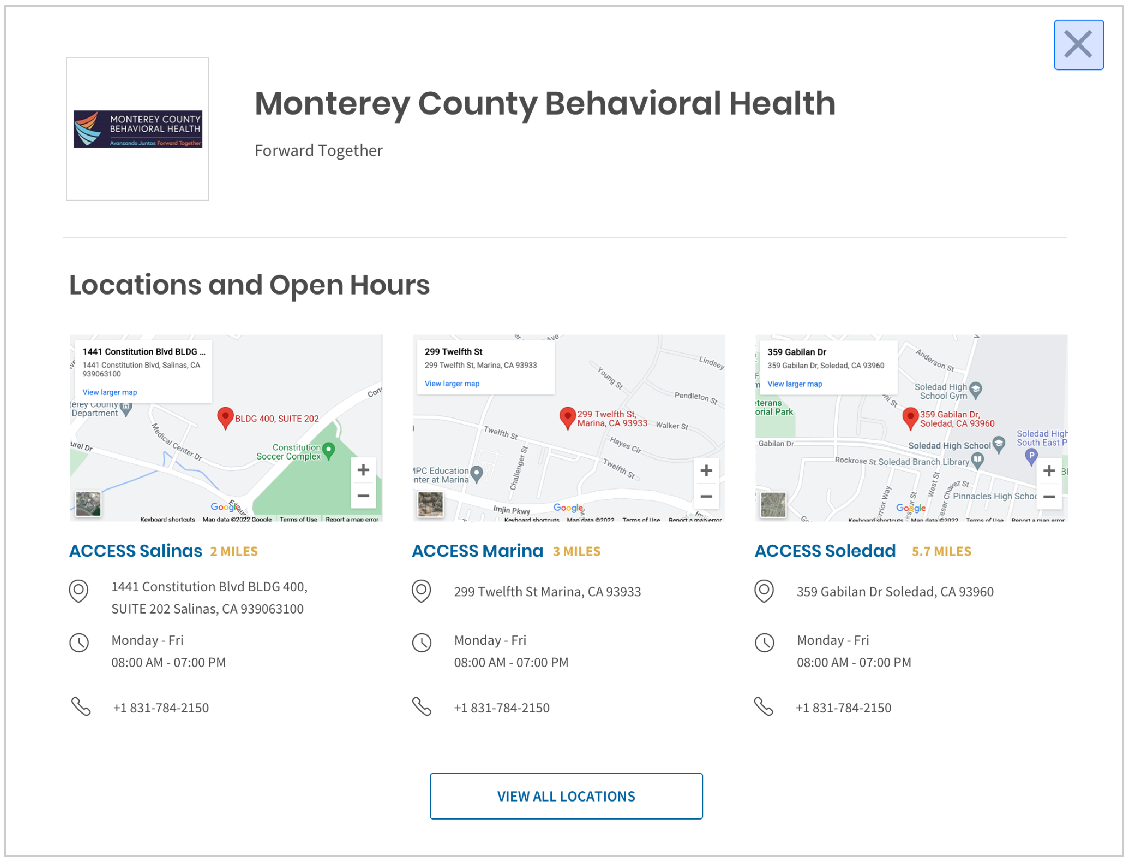
- The Access Code section text and option to scan a QR code were confusing to users. Text and options were changed to only include copying the Access Code, the link, or texting the link. Further refinement of site copy is under review.



- The Services now include the option of displaying multiple lists of resources. Each user may match to a higher number of services. The matching rules labels (i.e. "Match by Age") was appreciated during user tests.



- The Hours and Locations for an Organization or a Service has been updated to include phone numbers based on user feedback.



2. Estimated Completion Time

CredibleMind offers assessments to users of varying lengths. The assessment most similar in question length to the proposed screening tool is taking the majority of 1200 assessment takers 10-12 minutes to complete.

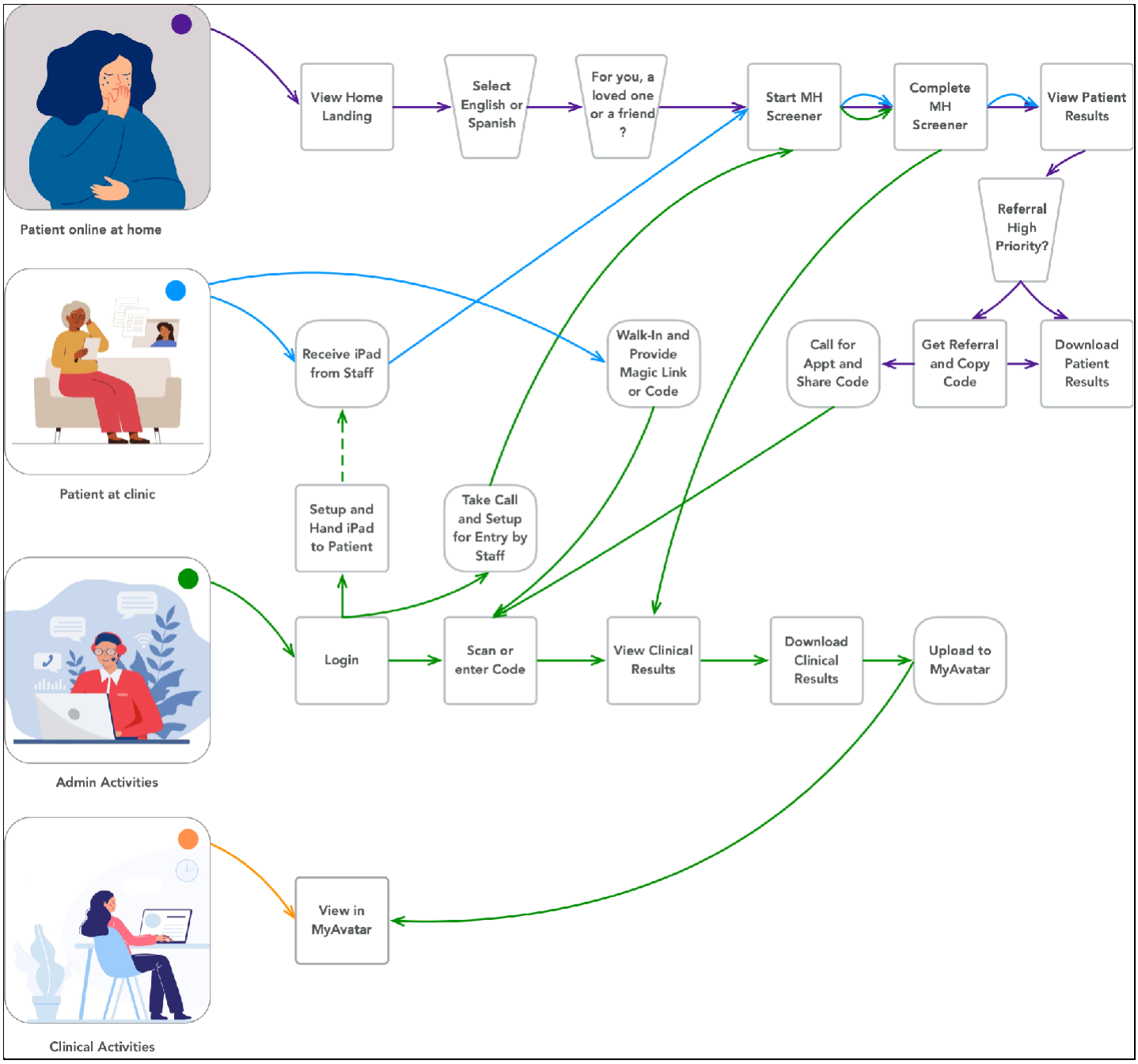
This estimated amount of time to complete is confirmed by initial testing of the English version via our survey platform in desktop mode. Based on our initial findings, we estimate the screening tool to take 5-6 minutes to complete for the minimum number of questions and 10-15 minutes to complete for the maximum number of questions. We plan to continue refining the completion time using our live platform on all devices (i.e. desktop, smartphone, tablet), with all use cases, and in both English and Spanish.

Upcoming changes to refinement process and estimated completion time As of May 11, 2022, CredibleMind has an unresolved change order request. If approved, additional refinement of the screening tool will be conducted. Throughout the remainder of the project until launch, we will continue to share updates to the prototypes and demo new and improved features of the live platform to stakeholders. A finalized estimated completion time will be determined using our live platform and submitted by September 12, 2022.

Appendix A

Milestones: User Journeys and Business Requirements

The following user journeys and business requirement analysis informed the application prototypes and will continue to guide the development tasks.



Business Requirements Analysis

Workflow Order	Category	Business Requirement	Feature	Feature Gap	Status
1	Site Instance	Each county has an instance of the site.	Configurable instances	No	Feature Ready
2	Site Instance	Instance is available in English or Spanish.	Support Spanish Content	No	Feature Ready
3	Onboarding	User sees a bilingual intro to the assessment	Bilingual home hero section	No	Feature Ready
4	Onboarding	User language is set when user selects screener language.	In flow language setting	No	Feature Ready
5	Onboarding	User can access emergency services info.	Need Help Now page	No	Feature Ready
6	Onboarding	User can learn about the project and what to expect.	Questions page	No	Feature Ready
7	Onboarding	User understands who can use the screener and what to expect.	Home Intro	No	Feature Ready
8	Assessment	User is addressed according to role (for self or someone else).	User pre-assessment question and text	Yes	Actionable - In Process
9	Assessment	User can take assessment in English or Spanish.	Support Spanish Assessment Content, a toggle to change between languages	No	Feature Ready
10	Assessment	User sees assessment adapt based on previous compilations of answers.	Adaptive assessment	Yes	Actionable - In Process
11	Assessment	User sees replicated questions suppressed or filled in.	Standardized question set	Yes	Actionable - Defined
12	Assessment	User can take assessment on an agency's tablet for the agency	User can select At the Clinic for workflow	Yes	Actionable - Defined
13	Results	User and clinical score notations meet workflow needs.	Results View	Yes	Actionable - Defined

14	Referral	User is provided clear referral instructions for key agencies if areas of concern	Highlighted referral options	Yes	Actionable - Defined
15	Referral	User is provided with broader options if no areas of concern	Highlighted self-care options	Yes	Actionable - Defined
16	Referral	User is provided with guidance to hand back	Highlighted return device message if At	Yes	Actionable - Defined

		device if in clinic	the Clinic is selected		
17	Results	User can download a PDF report of results summary info.	Results Report PDF	Yes	Actionable - In Process
18	Results	Clinical user views clinically oriented reports	Clinical Results View	Yes	Actionable - Defined
19	Results	User can download a PDF report of questions and answers.	Clinical Report PDF	Yes	Actionable - Defined
20	Results	User has option to access anonymous results later via QR Code, confirmation code or magic link.	User Access Code	Yes	Actionable - Defined
21	Authentica tio n	User can receive a text with the magic link/access code.	Request Text with Link	Yes	Actionable - Defined
22	Authentica tio n	User has option to create an account to access results later.	Various Sign In options	No	Feature Ready
24	Resources	User sees virtual resources for self-help, etc. related to results.	Display Self-Help Resources per Condition	No	Feature Ready
25	Resources	User sees filtered resources near them.	Display Services by Location	Yes	Actionable - Defined
26	Resources	User sees filtered resources for their insurance type or age range.	Display Services by insurance or age range	Yes	Actionable - Defined
27	Search	User can search for and find resources related to results and does not find any excluded resources.	Client configured search	Yes	Actionable - Defined

28	Admin	Project User can manage configurations for all instances.	Admin Tools - Resources	Yes	Actionable - Defined
29	Admin	Project User can manage roles for designated county admins.	Admin Tools - Users	Yes	Actionable - Defined
30	Admin	Project or County Admin User can manage configurations for one community instance.	Client Admin Tools	Yes	Actionable - Defined
31	Satisfaction	Users can provide satisfaction measures in form of Was your Site Visit Helpful or Assessment Helpful	User Satisfaction Surveys	No	Feature Ready

Appendix B: User Testing Script

Hello. Thank you for taking the time to provide feedback on our preliminary designs for the new Monterey County Behavioral Health Self-Screening Tool. This online quiz will let people know which mental health conditions they may be at risk for and provide recommendations of resources and referrals. This session will take 30 minutes. We will be showing you designs and please provide your honest feedback of what you like, what could be improved, and if there is anything you would change.

Show Invision #9
Part 1: What do you think this screening tool/quiz would show? Is this how you would like to be shown two different language options?

Part 2: What do you think about the guest code feature? What do you think it would do?

Show Invision #10
Do you think you would take the screening tool/quiz for someone else? When would this occur?

Show Invision #12
What do you think about the length of the tool/quiz? What do you think about the layout of the questions? Are there any questions that you do not feel comfortable answering? Are there any questions that you do not understand why we are asking?

Show Invision #13
Do you think you are more likely to click sign up or sign in as guest? Why?

Show Invision #14
What do you think about the results for the mental health screening tool/quiz for referrals? Do you find this page useful?

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e What would you like resources based on? Your
s demographics, interests or a combination of
? both? What, if anything, would you do next after
W looking at your risk scores?
o Would you be interested
u in downloading results?
l Why or why not? Would
d you email the results to
y yourself? Why or why

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8.0 Technical Documents

JUNE 30, 2022

The following pages include summaries and required deliverables for 8.0 Technical Documents for the Help@Hand screening application project. All parts are listed in the Table of Contents below.

Table of Contents

Business Requirements and Functional Design Documents

Business Requirements and Functional Design Documents were submitted as part of the 4.0 Functional Design Document deliverable on May 11, 2022 and approved on May 11, 2022. Documents can be delivered upon request.

Technical Design Document

Introduction to Technical Design

After completion of a Functional Design Document, CredibleMind has moved on to document the technical design of the solution for the Help at Hand Screener for Referrals. At a high level, CredibleMind offers configurable software as a service. For this project, all configurations will be grouped into Help at Hand for the purposes of supporting a standardized screening assessment, administration and reporting. For each county that chooses to engage, an instance with a unique subdomain will be created and unique local organizations and services along with key messaging will be configured based on a service mapping review process.

Technically, we will answer how we do this and how another technical team may do this in the future in the unlikely event that the relationship between Help at Hand and CredibleMind terminates.

Change Request Impact on Technical Design Document

As of May 11, 2022, CredibleMind has an unresolved change order request. If approved, this design document will serve as an initial draft and an updated version will be submitted by September 12, 2022.

1. Themes and Features

The Feature Gap analysis matrix includes themes and features. Some features are currently in production and can be configured or edited to achieve the workflow. These features are listed with Feature Gap is No. All other features are considered deliverables during the Application Development phase. These features are listed with Feature Gap is Yes.

Theme	Business Requirement	Feature
Site Instance	Each county has an instance of the site.	Configurable instances
Site Instance	Instance is available in English or Spanish.	Support Spanish Content
Onboarding	User sees a bilingual intro to the assessment	Bilingual home hero section
Onboarding	User language is set when user selects screener language.	In flow language setting
Onboarding	User can access emergency services info.	Need Help Now page
Onboarding	User can learn about the project and what to expect.	Questions page
Onboarding	User understands who can use the screener and what to expect.	Home Intro
Assessment	User can take assessment in English or Spanish.	Support Spanish Assessment Content, a toggle to change between languages
Assessment	User sees assessment adapt based on previous compilations of answers.	Adaptive assessment
Results	User can download a PDF report of results summary info.	Results Report PDF
Assessment	User is addressed according to role (for self or someone else).	User pre-assessment question and text
Assessment	User can take assessment on an agency's tablet for the agency	User can select At the Clinic for workflow
Referral	User is provided clear referral instructions for key agencies if areas of concern	Highlighted referral options
Referral	User is provided with broader options if no areas of concern	Highlighted self-care options
Referral	User is provided with guidance to hand back device if in clinic	Highlighted return device message if At the Clinic is selected
Results	User has option to access anonymous results later via confirmation code or magic link.	User Access Code
Notification	User can receive a text with the magic link/access code.	Request Text with Link
Assessment	User sees replicated questions suppressed or filled in.	Standardized question set
Results	User and clinical score notations meet workflow needs.	Results View
Results	Clinical user views clinically oriented reports	Clinical Results View
Results	User can download a PDF report of questions and answers.	Clinical Report PDF
Authentication	User has option to create an account to access results later.	Various Sign In options
Resources	User sees virtual resources for self-help, etc. related to results.	Display Self-Help Resources per Condition

Resources	User sees filtered resources near them.	Display Services by Location
Resources	User sees filtered resources for their insurance type or age range.	Display Services by insurance or age range
Search	User can search for and find resources related to results and does not find any excluded resources.	Client configured search
Admin	Project User can manage configurations for all instances.	Admin Tools - Resources

Admin	Project User can manage roles for designated county admins.	Admin Tools - Users
Admin	Project or County Admin User can manage configurations for one community instance.	Client Admin Tools
Satisfaction	Users can provide satisfaction measures in form of Was your Site Visit Helpful or Assessment Helpful	User Satisfaction Surveys

2. User Stories and Acceptance Criteria per Feature

CredibleMind uses design sprints to determine workflows which are visualized into mockups. The user workflow mockups have been through two rounds of user tests and have been reviewed by clinical stakeholders. Most workflow concerns have been resolved down to cosmetic and text level changes. With this said, the product team is following an agile process and can continue to be responsive to new findings. For all new functionality, each feature has a series of user stories and acceptance criteria as follows:

Feature	User Stories	Acceptance Criteria
Adaptive assessment	As a user I want to answer screener questions as efficiently as possible so I can get results quickly.	1. User sees branching questions only if they are required for the user to answer based on a prior question. 2. User sees branching questions based on the sum score of previous answers only when the user meets a min or max score. 3. User sees an immediately revealed branching question when context is important, for instance, the question is a follow-up. 4. User sees a delayed reveal of additional questions when the score from a series of questions determines the additional questions required. 5. User sees numbered question updates as questions are added for better context.

Results Report PDF	As a user I want the option to download my results so I can keep a record.	1. User sees a Download button on the results page. 2. When the user clicks Download a PDF is generated and downloaded without any additional steps required. 3. The user sees all key elements of the results excluding any submit buttons to other pages of the site. 4. Links are active on key links so that the user can go back to the site from the PDF.
User pre-assessment question and text	As a user I want to know the difference between my own results and the results I complete on behalf of someone else so I can review them later in my profile.	1. User can select an option to complete the screener for self or someone else. 2. Screeners completed for someone else are not displayed in the user's view of assessments if the user has created an account.
User can select At the Clinic for workflow	As a user at a clinic working with a client I want to hand them an iPad and ask them to take the screener so I can facilitate completion.	1. User can view an At the Clinic button from any menu header. 2. User can select the At the Clinic button and leave it on for any device across multiple sessions.

Highlighted referral options	As a user I want to know what I can do based on my areas of focus and concern so I can take my next step and refer myself.	1. User sees referral instructions based on levels of severity if At the Clinic is off. 2. Each county instance has varying referral instructions based on levels of severity. 3. User sees special referral instructions and messaging if under 16. 4. User sees special referral instructions and messaging if qualifying for Beacon EAP through a combination of severity and the user has Medi-Cal according to their insurance type answer.
Highlighted self-care options	As a user with lower areas of concern for all focus answers I want to see special instructions for considering my next step so I can refer myself if I prefer.	1. User sees a full panel layout of areas of concern with only the lower area of concern displayed. 2. User sees instructions about determining whether to refer oneself to services.
Highlighted return device message if At the Clinic is selected	As a user at a clinic working with a client I want to receive the iPad with the Access Code on the screen so I can use my EHR computer to download results and upload into their chart so we can reference it going forward.	1. User taking the screener can see a message to return the device with Access Code displaying instead of the typical highlighted referral instructions in results if At the Clinic mode was set to on.

User Access Code	As a user who has taken results, I want to see an access code and copy it or the full link so I can access my results later. As a user who has stored an access code I want to go back to a site and enter my access code later so I can view results. As a user who has stored a full link I want to click it so I can view my results online . As a user I want to know how to securely share my access code or a link with providers so I can get informed help.	1. User can enter an access code for any result and view it. 2. User taking a screener can view a result with an access code and may or may not have signed up during the prior screening workflow. 3. User can copy a full link and click it later to view results. 4. User is informed on how to keep their results secure when sharing their access code with providers.
Request Text with Link	As a user I want to request that a full link be sent to my phone via text so I can use the text to access my results later.	1. User can enter a mobile number and receive a text with a full link.
Standardized question set	As a user I don't want to answer questions more than once so I can complete the screener quickly.	1. User will only see questions that are unique based on time interval and wording. Note: this is waiting final review but may not require new functionality.
Results View	As a user viewing the screener I want to know the areas of concern that I have based on my answers. As a user viewing the screener I want to learn more about each area of concern so I can understand my options.	1. Any user completing an assessment or entering an access code will arrive at the patient results view. 2. User sees a summary view with scores categorized into three segments: Greater Area of Concern, Moderate Area of Concern and Lower Area of Concern. Exact language may change to match referral and treatment levels. 3. User may also see scores in clinical scale or standardized scale

		(0-100 scale).
Clinical Results View	As a user viewing the screener I want to know the scales used so I can understand the process. As a user viewing the screener results I want to know the patient's answers so I can review key questions. As a user viewing the screener results I want to know how the patient scored for each problem area so I will know how to treat them. As a user viewing the screener results I want to know when it was taken so I can understand if	1. Any user can view the clinical view of the results by clicking the Clinical View button. 2. User sees a summary view with similar patient results with scores in validated scale segments and worst to best order. 3. User may also see scores in standardized scale as a supplement if presented to the user in the Patient Results view (0-100 scale). 4. The clinical view has a per problem area with intro text displayed to patient 5. The clinical view has all the patient answers per problem area 6. The clinical view has the scale origin and scoring rules 7. User sees any guidance provided to the patient at the time they took the screener. 8. Links back to the Patient View are active.

	it's recent enough.	
Clinical Report PDF	As a user I want to download the complete clinical report so I can upload it into an EHR associated to the patient.	1. The user sees a Download Clinical Report button. 2. The PDF includes a full clinical view ordered by priority of content with patient scores per problem area first, patient answers and then validated score reference content that does not change per result. 3. Links back to the Clinical View are active.
Display Services by Location	As a user I want to know where services are offered so I can go to the most convenient location for me.	1. User sees all applicable services in card views under results. 2. User can allow detection of current location and see services nearest first. 3. User can deny detection of current location and see all services for the county. 4. User can select a city that may differ from current location and see all services nearest to the city first.
Display Services by insurance or age range and by priority	As a user I want to see services that are relevant to me so I can select one.	1. User with an age range will not see any services only offered for other age ranges. 2. User with an age range that matches services will see a matches your age label on the resource card if the service is offered for their age range. 3. User with an insurance type will not see any services only offered for other insurance types if appropriate. Note that most services accept all methods and filtering may not be advised. 4. User with an insurance type that matches services will see a matches your insurance label on the resource card if the service is offered for their insurance type. 5. User with a binary gender may not be required to view the opposite binary gender services if appropriate.
Client configured search	As a user I want to see services by name if I search for them.	1. User can search for services by name using the search box.
Admin Tools - Resources	As a user that administers the help at hand project I want to view user traffic and aggregate statistics so I can have insight.	1. User can view user traffic reports per county 2. User can view aggregate screener results stats per county 3. User can switch counties or view all in county. Note: Will use current reporting framework and UX.

Admin Tools - Users	As a user that administers the help at hand project I want to assign county users access rights so I can involve	1. An admin user can grant access for all Help at Hand users and for client admin users.

	them.	
Client Admin Tools	As a user that administers county services and organizations, I want to keep them up to date so I can direct referrals properly.	1. User can submit a form request for updates. 2. User can self serve edit key resources from a client admin portal. Note: Will expand use of current Client admin resources tools to include more resource types.

3. Confirmed and Elaborated User Workflows

Since the initial user tests were conducted in early April, problem areas were identified, updated and retested. Final end user and clinical user journeys are represented in the following responsive workflows:

Desktop: https://crediblemindfeedback602374.invisionapp.com/console/share/NFX4VZUQEWA
iPad: https://crediblemindfeedback602374.invisionapp.com/console/share/YSBJT6F9PQN
iPhone: https://crediblemindfeedback602374.invisionapp.com/console/share/9CUJPYE6R78

4. Technical Design

CredibleMind was founded in 2018 and the technical and product founders selected a modern technical stack designed from the outset to be serverless, responsive, localized and app migration friendly.

This is a summary and key areas are described below:

Stack Level	Services	Notes
User	Google Firestore/Firebase	Anonymous and Authenticated Screener Data
Auth	OAuth, SAML, Google, MSFT, FB	Allowed or required and per service
Data	Contentful, SurveyJS	Supports localization and configuration
Front End	JavaScript and React JS, CSS	
Back End	Python	
Services	Amazon CloudFront, AWS, Netlify	
Track	MixPanel, Google Analytics	Aggregated by county instance, event details
Test	Sentry, Selenium, Browserstack	Issue monitoring and test automation

Report	BigQuery, DataStudio, Sigma	Self serve and data feed using various formats including Tableau
Availability	BrowserStack, Jenkins	
Notifications	Mailchimp/Mandrill, AWS	Email and SMS for Transactional and Results

Support	FreshDesk	User Support Requests and KnowledgeBase

The technical design supporting the screening tool, user workflow business rules and user privacy are described here. The key technical design area for this workflow is the use of a user result level Access Code for retrieval of anonymous user results.

Secure Results Workflow

Users in possession of an access code will have access to a fully anonymized set of screener results on the platform. The access code will need to be paired with personal identification. Users will be instructed in safe methods for sharing their access code with a provider. This includes sharing the access code verbally and copying a link into a secure patient portal message.

Screener Design

The screener questions, answers, branching logic and result score options are all configured with the Survey JS tool. This tool outputs a JSON file that is then combined with contentful assessment and result segment content and expressed on the front end. A copy of all JSONs to produce the screener is available.

Serverless Architecture and Backup Processes

Since CredibleMind utilizes an entirely serverless tech stack, all backup processes are maintained with redundancy through third parties. For instance, all content and media on Contentful is automatically backed up by contentful to two physically separate data centers within Amazon Web Services on two continents, using Amazon's redundant S3 service (us-east-1 and eu-west-1). CredibleMind also maintains a series of backups of the master database.

5. Data Design

Content data including page level copy is stored in the contentful system. Contentful is an enterprise serverless content management system with tables of data and relationships between them. CredibleMind manages environment instances and localization into the Spanish language from contentful. Records of key importance to each county configuration are a county level record, page copy for each page of the site and the referral messaging, organizations, services and locations that comprise the recommended referrals in the results view. These are all considered custom to each county. Records of key importance to the screener include an assessment record and multiple assessment results.

Services Content Data

The contentful database includes service related content types for Services offered by each location with fields that manage the following:

1. **Content:** Each content type includes the localized site copy fields for displaying a card or page view of the Services including a url and media.
2. **Related Content:** The Services map to one organization and to many locations.

3. **County Ownership:** The Services are restricted to the client representing the county.
4. **Filtering Criteria:** Location, Audiences, Tags, Cost Description and Topic Themes contribute to the mapping of the Services to User Location, Demographics and Assessment Result data.
5. **Audit**: Contentful manages publishing status, owner and

update audit trails. See Appendix B for Services and Locations JSON structure samples in this document.

Assessment and Results Content Data

For assessments, the team uses proprietary administrative tools based on Survey.JS to create and edit an assessment JSON. The contentful database includes assessment related content types for the Assessment which has many related Assessment Result records.

1. **Content:** Each assessment includes the localized site copy fields for displaying a card or page view of the assessment intro and questions.
2. **Related Results:** Each assessment also has related assessment results that display based on a user's component scores.
3. **County Ownership:** The Mental Health Screening Assessment is restricted to participating counties.
4. **Audit**: Contentful manages publishing status, owner and update audit trails.

User Data

The user data residing in firebase is written for users creating an account or using a social sign on. Any user profile information will also be written from assessment results. An example user account appears as follows:

brand: "testmonterey"
displayName: "First Last" dob:
"[45-54]"
email: "first.last@crediblemind.co" gender:
"Female"
industry: "Working in healthcare"
insuranceType: "Medi-cal/Medicaid" role:
"user"

Anonymous users are tracked per assessment taken. User activity can be combined across multiple sessions on the same device if not private browsing. A user with an account has the added advantage of having a view history, favorited resources and past assessment results.

6. Application and System Architecture

For this project CredibleMind is using a modern browser based application architecture with all code being secure serverless functions and API's.

React Application

The front end technology is a fully browser based application — this means there are no servers involved for the app to work. Each user accessing the site gets the code delivered to their browser that than

makes secure API calls to render each page in the browser. This technology, react-js, is what powers most of the modern application frameworks.

Search and AI-based Recommendations

CredibleMind uses a search optimization service, Algolia, that includes methods for determining results based on user keywords and previous user activity. All county proprietary services are both locally filtered and client filtered to achieve the best search results.

Business Rules and Hierarchy

CredibleMind manages features and settings at the platform level, the client parent level or client level for the most flexibility. In this case, the client parent is Help at Hand and the client is each county. CredibleMind uses client parent or client level feature toggles to achieve proprietary workflows, and in most cases, they will override any standard platform level configurations. All change requests are analyzed for configuration suitability. Some examples are as follows:

- Screener Questions: Client Parent or Project Level
- Screener Results per Condition: Client Parent or Project Level
- Screener Referrals: Client Level for each county
- Services and Locations: Client Level for each county
- Self-help Resources by Topic: Platform Level
- Self-help Resource Exclusions by Topic: Client Level for each county

Please note that the ERD infers the above business logic.

Application Security

CredibleMind has extensive security policies and procedures. We can make these available upon request.

User Credentials and Authentication including Single Sign On (SSO)

For sign in processes, each county can elect to offer Google, Microsoft, Facebook and native registration processes. If desired, a county may require login to use the service. To date, county stakeholders have concurred that a primarily anonymous workflow with a unique identifier in the form of an Access Code per anonymously presented result is preferred for sensitive mental health information. Google, Microsoft and Facebook social sign-ins are seamlessly tied to additional questions for age range, gender and industry. For native registration on CredibleMind, users can create an account using an email address as a unique username and strong password. If the user forgets a password, there is an automated forgotten password workflow with a temporary link to reset sent to the user's email address.

Reporting and API Architecture

All user data including assessment results are stored and can be reported. The data is combined into a reporting optimized database in Google Big Query and then managed by date ranges and visualized using Sigma. Each client or county will have its own silo which can be combined for project reporting. Results can be associated with unique users if the user has an account. User events such as viewing an

assessment or completing can be associated across devices or by location for users that are not private browsing.

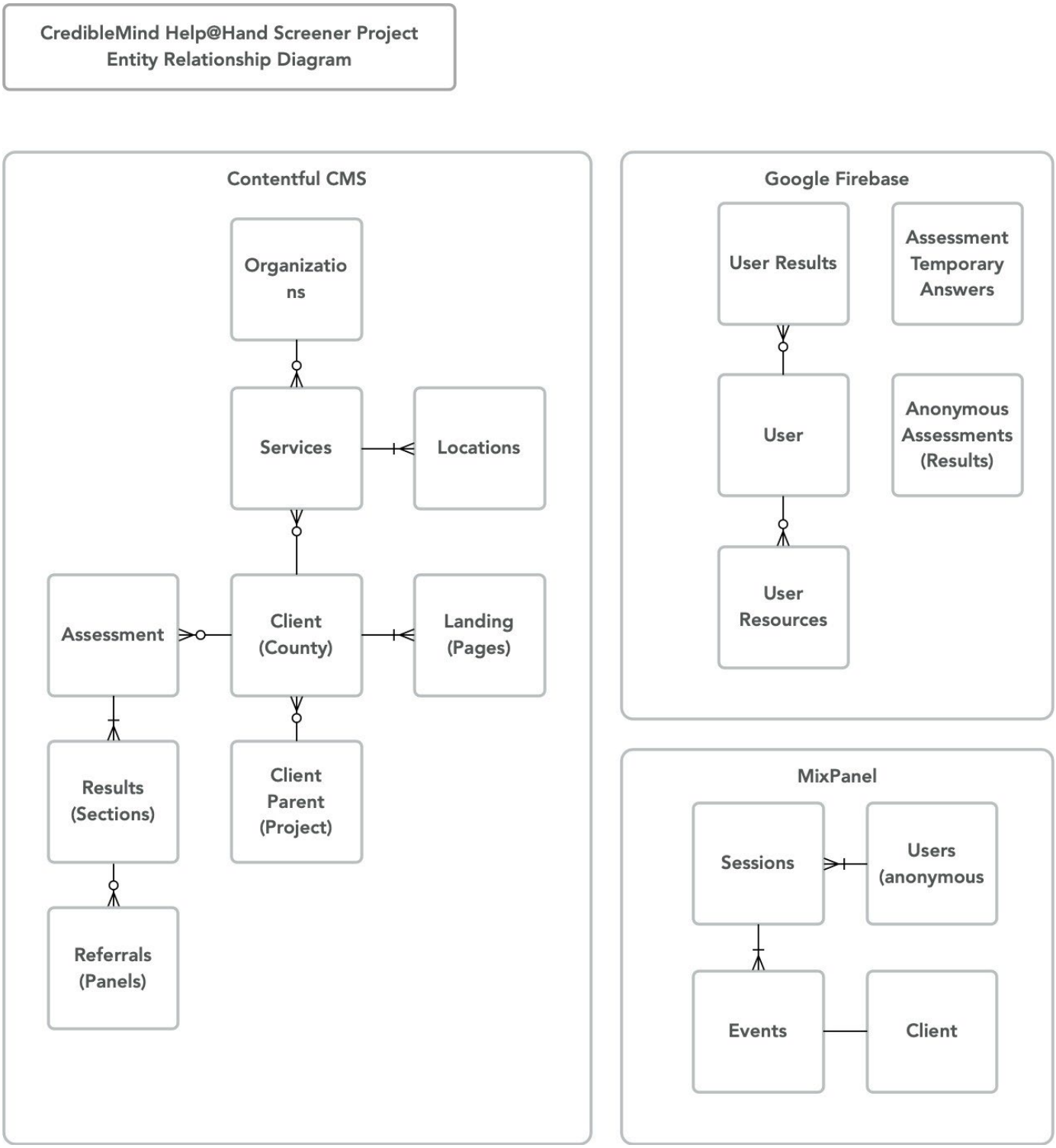
Aggregate reporting is managed for all data sensitive assessment results to ensure privacy. For instance, results detail reports are restricted to the aggregated datasets for a range that includes a significant number of results.

Testing Architecture

The development and quality assurance activities within the software development process include 24/7 monitoring for alerts through Sentry, a third party service which reports various error conditions with the technical detail associated to ensure the remediation of issues. Feature availability and functionality is monitored through selenium test scripts that are then automated across all supported browsers and devices using BrowserStack, a third party tool that emulates combinations of browser, OS and device for front end testing. Developers also write unit tests and monitor for issues within builds.

7. Entity Relationship Diagram (ERD)

The data ecosystem includes Google Firebase for user data, the Contentful content management system and Mixpanel events for reporting. These primary datasets are combined into Google BigQuery for the purpose of generating reports. *Please note that Self-help resources and measures of satisfaction were removed from this diagram for the purpose of focusing on the primary workflow.*



The relationships across data systems are maintained through consistent use of client identifiers and slugs as unique identifiers. For instance, the assessment taken from the contentful database, the firebase assessment results and the assessment completed event all share the same client brand and slug. Data Models of Assessments, Results, Services, Locations and Users are listed within this document.

8. Data Dictionary

Google Firebase User Data

The Google Firebase Realtime Database is a cloud-hosted database. Data is stored in JSON and synchronized in real time to every connected mobile or other client. It lets developers build rich collaborative applications, with data also persisted locally, to give users a responsive experience. Samples are included for user data. A full data dictionary can be generated if requested.

Contentful Content Management Data

The Contentful Content Database is a cloud-hosted database as well. Data is also stored in JSON and synchronized in real time. Sample data dictionary details are located in Appendix A for Assessments and Appendix B for Services and Locations. A full data dictionary can be generated if requested.

9. HIPAA, PHI and FedRamp Compliance

CredibleMind does not receive PHI from any covered entity to implement any workflows and are not acting as Business Associates under HIPAA. However, we are following HIPAA and PHI best practices for security and privacy. Please see the HIPAA and other policies in our Info Sec policies which have been uploaded separately and can be emailed upon request.

As a serverless architecture, the CredibleMind platform uses the following Federal Risk and Authorization Management Program (FedRamp) compliant cloud service providers for data storage and meet FedRamp Moderate standards at the locations used by CredibleMind.

Amazon Web Services

AWS US East-West (Northern Virginia, Ohio, Oregon, Northern California) has been granted a Joint Authorization Board Provisional Authority-To-Operate (JAB P-ATO) and multiple Agency Authorizations (A-ATO) for moderate impact level. The services in scope of the AWS US East-West JAB P-ATO boundary at Moderate baseline security categorization can be found within AWS Services in Scope by Compliance Program. See also: Amazon Web Services (AWS) FedRamp Policy.

Google Cloud

Google Services including Firestore/Firebase and BigQuery meet FedRamp High and Moderate standards. See the Google Cloud FedRamp Compliance Statement.

Third-Party Assessment

Third-party assessment and audits for SOC-2/3 compliance are conducted by both Google Cloud and Amazon Web Services. Google cloud audit reports are available here and AWS cloud audit reports have been uploaded separately. We also use Qualys to conduct routine 3rd-party vulnerability and penetration testing. The latest Qualys test has been uploaded separately. We will continue to have the 3rd-party scans run as we complete the development and have a final application for testing.

10. Application Workflow

The full workflow prototype for user testing is a dynamically updated mockup of screens to help communicate workflow and user experience. CredibleMind uses a software called InVision to design mockups and test out workflows and prototypes. All user personas and workflows are represented with detailed emphasis on feature gaps including referral workflows. Key onboarding features include:

1. A primary call-to-action to start screening in English or Spanish
2. Option to view Need Help Now resources
3. Option to view Frequently Asked Questions
4. Option to Sign Up and Create an Account
5. Option to retrieve a prior result anonymously via an Access Code

The following key application and referral process features include:

1. Guidance to user taking Screener for self or on behalf of someone else
2. Branching and adaptive Screener questions including demographics collection
3. User results categorized by levels of concern per result scale segmentation
4. User referral guidance to a primary behavioral health agency and also to other local resources
5. Segmentation of referral guidance by age range, insurance type and other factors
6. Prioritization of referral locations by user detected location or specified city
7. Anonymous or signed in user option to share an Access Code to retrieve anonymized results
8. User option to create an account and save results to a user profile
9. Users with account created may have results emailed to them
10. All users may download results

Onboarding and application prototypes are being dynamically updated. There is a slide deck with screenshots that serves as a record of the user testing version (Appendix E as additional upload). To access the onboarding and application prototypes in responsive screen widths, follow these links:

Desktop: https://crediblemindfeedback602374.invisionapp.com/console/share/NFX4VZUQEWA
iPad: https://crediblemindfeedback602374.invisionapp.com/console/share/YSBJT6F9PQN
iPhone: https://crediblemindfeedback602374.invisionapp.com/console/share/PWTDUCQKXE4

Prototype of Ability for Provider to Access User Results

To ensure that providers do not need to be authenticated and credentialed, all provider functionality is offered within the main workflows. Please reference the links above under Onboarding Prototype. Key features include the following:

1. An At the Clinic mode uses appropriate prompts to users at the end of a screening
2. View Clinical Results options are offered from the home screen and from specific results
3. Provider can receive an Access Code from a user who has taken the screening and view anonymized results
4. Clinical Results include user item responses and validated scale information

5. Clinical Results PDF may be downloaded for upload into an EHR

Live Platform Configuration with Questions

The live working configuration is now available on the CredibleMind platform. It includes features marked “not a feature gap” in the Business Requirements (available upon request). It also includes the complete draft set of screening questions. Key functionality includes:

1. A primary call-to-action to start screening in English or Spanish
2. Option to view Need Help Now resources
3. Option to view Frequently Asked Questions
4. Option to Sign Up and Create an Account
5. Answer screener questions on behalf of self
6. Placeholder questions and results (screener does not represent final set of questions)

To access the live platform configurations, follow these links:

Test Site in Production Environment:	testmonterey.crediblemind.com
Test Site in Staging Environment:	cm-staging.netlify.app/?brand=testmonterey

11. Hosting and Access Options

CredibleMind offers hosting and access as a stand-alone site or embedded within an existing site. Stand-alone options and features are as follows:

- Option 1: Any available subdomain of crediblemind.com such as monterey.crediblemind.com
- Option 2: A purchased domain of your choice such as screenme.info
- Includes deep linking management
- Advantages - Easy to launch and link current county pages to it

Embedded options are as follows:

- Embed within your menu header on a page (Instructions in Separate Document provided)
- Takes a web developer an hour or two to set up and test
- Managed through CredibleMind platform self serve tools and service team
- Includes deep linking management using your domain
- Advantages - Easy to direct existing users and retain users on your site

Appendix H: Draft Screening Tool

CredibleMind

Appendix B: July draft of screening questions

Outline of structure

When users enter the screening homepage, they will see two options to take the screener: one in English and one in Spanish. Clicking START

will take them to the English version of the screener and clicking TOMAR will take them to the Spanish version.

Then, users will be asked the following questions and scales in order:

Page number	Category/Condition	Number of questions	Scale
1	Introductory demographics	4	n/a
2	Depression and Anxiety screening	4	PHQ-4
	Anxiety branching	+5	Rest of GAD-7
	Depression branching	+7	Rest of PHQ-9
3	Postpartum Depression branching	+10	Edinburgh Postnatal Depression Scale
4	Trauma/PTSD screening	1	PC-PTSD-5
	Trauma/PTSD branching	+5	Rest of PC-PTSD-5
5	Bipolar affectivity frequency	8	WERCAP (Washington Early Recognition Center Affectivity and Psychosis Screen)

	Bipolar affectivity functionality branching	+1-3	WERCAP
	Substance-induced affectivity symptoms item	+1	WERCAP
6	Psychosis frequency	8	WERCAP

	Psychosis functionality branching	+1-8	WERCAP
	Substance-induced psychosis symptoms item	+1	WERCAP
7	(NEW) Eating disorders	5	SCOFF (Sick, Control, One, Fat, Food)
8	Substance use screening (21 and older)	5	TAPS (Tobacco, Alcohol, Prescription medication, and other Substance use) Part I
9	Tobacco and alcohol use branching	+1-7	TAPS Part II
10	Cannabis, stimulants (cocaine, crack, meth), and heroin branching	+1-9	TAPS Part II
11	Opioid, sedative, stimulant (Adderall, Ritalin), and other illegal or recreational drug branching	+1-10	TAPS Part II
12	Substance use screening (Under 21)	5	CRAFFT (Car, Relax, Alone, Forget, Friends, Trouble) 2.1+N (Nicotine)
13	Substance use branching (Under 21)	+5	CRAFFT 2.1+N
14	Nicotine branching (Under 21)	+15	CRAFFT 2.1+N
15	Concluding demographics (Prior behavioral health experience and social determinants of health)	4	n/a
16	Concluding demographics (Zip code, race/ethnicity, preferred language, local programs/services, health insurance)	7	n/a

Total question count:

Category/Condition	**Minimum number of questions**	**Maximum number of questions**
Anxiety	2	7
Depression	2	9
Postpartum depression	0	10
Trauma/PTSD	1	6
Bipolar	8	11
Psychosis	8	16
Substance-induced bipolar or	0	2

psychosis		
Eating disorders	5	5

Substance use		
- 21 and older	5	31
- Under 21	5	20
Demographics	15	15
TOTAL for non-pregnant youth	**46**	**91**
TOTAL for non-pregnant adult	**46**	**102**

English and Spanish draft versions

Page 1 of screener

Welcome! The questions below will help guide the questions you see later on. This questionnaire is anonymous. Your individual results will not be shared unless you choose to share them yourself.
¡Bienvenido! Las siguientes preguntas ayudarán a guiar las preguntas que le mostramos más adelante. Este cuestionario es anónimo. Sus resultados individuales no se compartirán a menos que elija compartirlos usted mismo.[1]

Category/ Scale	**Audience/ Branching**	**Question**	**Question type**	**English responses**	**Spanish responses**
Intro Demographic	All	How old are you? ¿Cuántos años tiene Ud.?	Multiple choice	0|15 or younger 1|16-17 years old 2|18-20 years old 3|21-24 years old 4|25-34 years old 5|35-44 years old 6|45-54 years old 7|55-64 years old 8|65 or over	0|15 años o menos 1|16-17 años 2|18-20 años 3|21-24 años 4|25-34 años 5|35-44 años 6|45-54 años 7|55-64 años 8|65 años o más
Intro Demograph	All	What is your gender? ¿Cuál es su género?	Multiple	0|Female 1|Male 2|Trans Woman 3|Trans Man 4|Non-binary 5|Genderqueer/ non-	0|Mujer 1|Hombre 2|Mujer trans 3|Hombre trans 4|No binarie 5|Genderqueer

ic			choice	conforming 6|I prefer not to say	/no conforme 6|Prefiero no decir
Intro Demographic	All	Are you pregnant or have you recently been pregnant? ¿Está embarazada o ha estado embarazada recientemente?	Binary	1|Yes 0|No	1|Sí 0|No

[1] All Spanish translations that did not come from researcher-translated scales have undergone cultural review

Intro Demographic	All	Have you been diagnosed for any of the conditions below, whether currently or in the past? Please check all that apply. ¿Ha sido diagnosticado con alguna de las siguientes condiciones, ya sea actualmente o en el pasado? Por favor marque todos los que apliquen.	Checklist	0|Anxiety disorder 1|Depression 2|Bipolar disorder 3|Postpartum or perinatal depression 4|Eating disorder 5|Personality disorder 6|PTSD 7|Substance use disorder 8|Schizophrenia 9|I prefer not to say 10|None of the above Other mental health condition	0|Ansiedad 1|Depresión 2|Trastorno bipolar 3|Depresión posparto o después del parto 4|Trastorno alimentario 5|Trastorno de personalidad 6|TEPT 7|Trastorno por consumo de sustancias 8|Esquizofrenia 9|Prefiero no decir 10|Ninguna de las anteriores Otra condición de salud mental

Page 2 of screener

Over the last two weeks, how often have you been bothered by the following problems?
Durante las últimas 2 semanas, ¿qué tan seguido ha tenido molestias debido a los siguientes problemas?

Category/ Scale	Audience/ Branching	Question	Question type	English responses	Spanish responses
PHQ-4	All	1. Feeling nervous, anxious or on edge Se ha sentido nervioso(a), ansioso(a) o con los nervios de punta	4x4 Matrix	0|Not at all 1|Several days 2|More than half the days 3|Nearly every day	0|Ningún día 1|Varios días 2|Más de la mitad de los días 3|Casi todos los días
		2. Not being able to stop or control worrying No ha sido capaz de parar o controlar su preocupación			
		3. Feeling down, depressed or hopeless Se ha sentido decaído(a), deprimido(a) o sin esperanzas			
		4. Little interest or pleasure in doing things Poco interés o placer en hacer cosas			

ANXIETY BRANCHING—A score of 3 or more on questions 1 and 2 of the PHQ-4 would lead to the following:

Over the last two weeks, how often have you been bothered by the following problems?
Durante las últimas 2 semanas, ¿qué tan seguido ha tenido molestias debido a los siguientes problemas?

Category/ Scale	Audience/ Branching	Question	Question type	English responses	Spanish responses
GAD-7	PHQ-4	3. Worrying too much about different things Se ha preocupado demasiado por motivos	5x4 Matrix	0|Not at all 1|Several days 2|More than half the days 3|Nearly every day	0|Ningún día 1|Varios días 2|Más de la mitad de los días 3|Casi todos los días
	Anxiety Screening ≥ 3	diferentes			
		4. Trouble relaxing Ha tenido dificultad para relajarse			
		5. Being so restless that it is hard to sit still Se ha sentido tan inquieto(a) que no ha podido quedarse quieto(a)			
		6. Becoming easily annoyed or irritable Se ha molestado o irritado fácilmente			
		7. Feeling afraid, as if something awful might happen Ha tenido miedo de que algo terrible fuera a pasar			

DEPRESSION BRANCHING—A score of 3 or more on questions 3 and 4 of the PHQ-4 would lead to the following:

Over the last two weeks, how often have you been bothered by the following problems?
Durante las últimas 2 semanas, ¿qué tan seguido ha tenido molestias debido a los siguientes problemas?

Category/ Scale	Audience/ Branching	Question	Question type	English responses	Spanish responses
		3. Trouble falling or staying asleep, or sleeping too much Ha tenido dificultad para quedarse o permanecer dormido(a), o ha dormido demasiado			
		4. Feeling tired or having little energy Se ha sentido cansado(a) o con poca energía			

PHQ-9	PHQ-4 Depression Screening ≥ 3	5. Poor appetite or overeating Sin apetito o ha comido en exceso	7x4 Matrix	0|Not at all 1|Several days 2|More than half the days 3|Nearly every day	0|Ningún día 1|Varios días 2|Más de la mitad de los días 3|Casi todos los días
		6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down Se ha sentido mal con usted mismo(a)—o que es un fracaso o que ha quedado mal con usted mismo(a) o con su familia			
		7. Trouble concentrating on things, such as reading the newspaper or watching television Ha tenido dificultad para concentrarse en ciertas actividades, tales como leer el periódico o ver la televisión			
		8. Moving or speaking so slowly that other people could have noticed? Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual ¿Se ha movido o hablado tan lento que otras personas podrían haberlo notado? o lo contrario—muy inquieto(a) o agitado(a) que ha estado moviéndose mucho más de lo normal			
		9. Thoughts that you would be better off dead or of hurting yourself in some way Pensamientos de que estaría mejor muerto(a) o de lastimarse de alguna manera			

Page 3 of screener

POSTPARTUM DEPRESSION BRANCHING—Selecting 1 ("Yes") to *Are you pregnant or have you recently been pregnant?* would lead to the following set of questions:

Because you told us you are pregnant or have recently been pregnant, we would like to know how you are feeling. Please choose the answer that comes closest to how you have felt IN THE PAST 7 DAYS, not just how you feel today.
Como usted está embarazada o ha estado embarazada recientemente, nos gustaría saber como se siente actualmente. Por favor marque la respuesta que más se acerca a como se ha sentido durante LOS ÚLTIMOS 7 DÍAS y no sólo como se ha sentido hoy.

Category/ Scale	Audience/ Branching	Question	Question type	English responses	Spanish responses

EPDS	"Yes" to pregnancy screener item	*5 I have felt scared or panicky for no very good reason He sentido miedo o pánico sin motivo alguno	4-point scale	3|Yes, quite a lot 2|Yes, sometimes 1|No, not much 0|No, not at all	3|Sí, bastante 2|Sí, a veces 1|No, no mucho 0|No, en absoluto
EPDS	"Yes" to pregnancy screener item	*6. Things have been getting on top of me Las cosas me oprimen o agobian	4-point scale	3|Yes, most of the time I haven't been able to cope at all 2|Yes, sometimes I haven't been coping as well as usual 1|No, most of the time I have coped quite well 0|No, I have been coping as well as ever	3|Sí, la mayor parte del tiempo no he podido sobrellevarlas 2|Sí, a veces no he podido sobrellevarlas de la manera 1|No, la mayoría de las veces he podido sobrellevarlas bastante bien 0|No, he podido sobrellevarlas tan bien como lo hecho siempre
EPDS	"Yes" to pregnancy screener item	*7. I have been so unhappy that I have had difficulty sleeping Me he sentido tan infeliz, que he tenido dificultad para dormir	4-point scale	3|Yes, most of the time 2|Yes, sometimes 1|Not very often 0|No, not at all	3|Sí, casi siempre 2|Sí, a veces 1|No muy a menudo 0|No, en absoluto
EPDS	"Yes" to pregnancy screener item	*8. I have felt sad or miserable Me he sentido triste y desgraciada	4-point scale	3|Yes, most of the time 2|Yes, quite often 1|Not very often 0|No, not at all	3|Sí, casi siempre 2|Sí, bastante a menudo 1|No muy a menudo 0|No, en absoluto
EPDS	"Yes" to pregnancy screener item	*9. I have been so unhappy that I have been crying Me he sentido tan infeliz que he estado llorando	4-point scale	3|Yes, most of the time 2|Yes, quite often 1|Only occasionally 0|No, never	3|Sí, casi siempre 2|Sí, bastante a menudo 1|Ocasionalmente 0|No, nunca
EPDS	"Yes" to pregnancy screener item	*10. The thought of harming myself has occurred to me He pensado en hacerme daño	4-point scale	3|Yes, quite often 2|Sometimes 1|Hardly ever 0|Never	3|Sí, bastante a menudo 2|A veces 1|Casi nunca

					0|No, nunca

*Items marked with an asterisk are reverse-scored

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Sometimes things happen to people that are unusually or especially frightening, horrible, or traumatic. For example: a serious accident or fire, a physical or sexual assault or abuse, an earthquake or flood, a war, seeing someone be killed or seriously injured, having a loved one die through homicide or suicide.

A veces, a las personas les suceden cosas inusualmente o especialmente aterradoras, horribles o traumáticas. Por ejemplo: un accidente o incendio grave, una agresión o abuso físico o sexual, un terremoto o una inundación, una guerra, ver a alguien morir o lesionarse gravemente, que un ser querido muera por homicidio o suicidio.

Category/ Scale	Audience/ Branching	Question	Question Type	English responses	Spanish responses
PC-PTSD-5	All	1. Have you ever experienced this kind of event? ¿Alguna vez ha experimentado este tipo de evento?	Boolean	1|Yes 0|No	1|Sí 0|No

TRAUMA/PTSD BRANCHING—Selecting 1 ("Yes") to the above question: *Have you ever experienced this kind of event?* would lead to the following set of questions:

In the past month, have you...
Durante el último mes, ¿usted...

Category/ Scale	Audience/ Branching	Question	Question Type	English responses	Spanish responses
PC-PTSD-5	"Yes" to PTSD screener	2. Had nightmares about it or thought about it when you did not want to? ¿Ha tenido pesadillas perturbadoras o piensa sobre esa experiencia sin quererlo?	Boolean	1|Yes 0|No	1|Sí 0|No
		3. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it? ¿Ha tratado, sin logro, de no pensar en la experiencia, o ha tratado a toda costa (o a todo costo) de evitar situaciones que le recuerden esa experiencia?			
		4. Been constantly on guard, watchful, or easily startled? ¿Ha estado a la defensiva, vigilante de su entorno, o se sobresalta fácilmente desde que tuvo esa experiencia?			

	item	5. Felt numb or detached from others, activities, or your surroundings? ¿Ha tenido sensaciones de entumecimiento en los brazos o en las piernas; se ha sentido aislado o desprendido de otros (amigos, seres queridos), de su entorno, o de actividades que disfrutaba antes?			
		6. Felt guilty or unable to stop blaming yourself or others for the event(s) or any problems the event(s) may have caused? ¿Ha sentido culpable o incapaz de dejar de culparse a sí mismo oa los demás por los eventos o cualquier problema que los eventos puedan haber causado?			

BIPOLAR FUNCTIONING BRANCHING—Selecting a response greater than 0 ("No") on questions 1a, 3a, or 6a will display an additional question below for each that assesses functioning.

All screener pages related to the WERCAP will display the following page intro: *The next set of questions may feel sensitive or strange to answer. We ask these questions to everyone who takes this screener in order to get the most complete picture of your mental health. Please be as honest as possible. As a reminder, your responses are private and anonymous unless you choose to share them.*

El siguiente conjunto de preguntas puede parecer delicado o extraño de responder. Hacemos estas preguntas a todos los que hacen esta evaluación para obtener una imagen más completa de su salud mental. Por favor, sea lo más honesto posible. Como recordatorio, sus respuestas son privadas y anónimas a menos que elija compartirlas.

Please indicate how frequently you experience each item over the past 3 months

Por favor indique con qué frecuencia ha experimentado cada elemento en los últimos 12 meses

Category/ Scale	Audience/ Branching	Question	Question Type	English responses	Spanish responses
WERCAP	All	1a. I have had sadness or depression lasting 1 month or longer He tenido tristeza o depresión durante un mes o más	6-point scale	0|No 1|Once 2|Rarely (less than yearly) 3|Sometimes (more than yearly to monthly) 4|Often (more than monthly to weekly) 5|Almost always (more than weekly to daily)	0|No 1|Una vez 2|Raramente (menos de una vez al año) 3|Algunas veces (más de una vez al año a una vez al mes) 4|A menudo (más de una vez al mes a una vez a la semana) 5 |Casi siempre (más de semanalmente a diario)

WERCAP	Question 1a > 0	1b. How much did it affect your functioning at home, work, or school, or with other people? ¿Cuánto afectó su funcionamiento en el hogar, el trabajo, la escuela o con otras personas?	Dropdown	0|Not at all 1|A little 2|Moderatel y 3|Severely	0|Nada 1|Un poco 2|Moderadamente 3|Severamente
WERCAP	All	2. I have been sad or depressed AND slept 5 hours or more than I normally do He estado triste o deprimido y he dormido cinco horas o más de lo normal	6-point scale	0|No 1|Once 2|Rarely (less than yearly) 3|Sometimes (more than yearly to monthly) 4|Often (more than monthly to weekly)	0|No 1|Una vez 2 |Raramente (menos de una vez al año) 3|A veces (más de una vez al año a una vez al mes) 4|A menudo (más de una vez al mes a una semana) 5|Casi siempre (más de una

				5|Almost always (more than weekly to daily)	semana a una vez al día)
WERCAP	All	3a. I have become angry for most of the day because of little things Me he enfadado la mayor parte del día por cosas pequeñas	6-point scale	0|No 1|Onc e 2|Rarely (less than yearly) 3|Sometimes (more than yearly to monthly) 4|Often (more than monthly to weekly) 5|Almost always (more than weekly to daily)	0|No 1|Una vez 2|Raramente (menos de una vez al año) 3|A veces (más de una vez al año a una vez al mes) 4|A menudo (más de una vez al mes a una vez a la semana) 5|Casi siempre (más de semanalmente a diario)
WERCAP	Question 3a > 0	3b. Did it ever lead to any problems at home, work or school, or with other people ¿Alguna vez le generó algún problema en el hogar, el trabajo o la escuela o con otras personas?	Dropdown	0|Not at all 1|A little 2|Moderatel y 3|Severely	0|Nada 1|Un poco 2|Moderadamente 3|Severamente
WERCAP	All	4. I have had sudden shifts between sadness and happiness for no apparent reason He tenido cambios repentinos entre la tristeza y la felicidad sin razón aparente	6-point scale	0|No 1|Onc e 2|Rarely (less than yearly) 3|Sometimes (more than yearly to monthly) 4|Often (more than monthly to weekly) 5|Almost always (more than weekly to daily)	0|No 1|Una vez 2|Raramente (menos de una vez al año) 3|A veces (más de una vez al año a una vez al mes) 4|A menudo (más de una vez al mes a una vez a la semana) 5|Casi siempre (más que semanalmente a diario)

WERCAP	All	5. I have had extreme happiness or “highs” that others thought were excessive lasting 2 days or longer He tenido una felicidad extrema o “elevaciones” que otros pensaban que eran excesivas y que duraban dos días o más	6-point scale	0|No 1|Onc e 2|Rarely (less than yearly) 3|Sometimes (more than yearly to monthly) 4|Often (more than monthly to weekly) 5|Almost always (more than weekly to daily)	0|No 1|Una vez 2|Raramente (menos de una vez al año) 3|A veces (más de una vez al año a una vez al mes) 4|A menudo (más de una vez al mes a una semana) 5|Casi siempre (más de una vez a una semana a una vez al día)
WERCAP	All	6a. I have had so much energy that I felt little or no need to sleep He tenido tanta energía que sentí poca o ninguna	6-point scale	0|No 1|Onc e 2|Rarely (less than yearly) 3|Sometimes (more	0|No 1|Una vez 2|Raramente (menos de una vez al año) 3|Algunas veces (más de

		necesidad de dormir		than yearly to monthly) 4|Often (more than monthly to weekly) 5|Almost always (more than weekly to daily)	una vez al año a una vez al mes) 4|A menudo (más de una vez al mesa semanal) 5|Casi siempre (más de semanal a diario)
WERCAP	Question 6a > 0	6b. What was the longest time you slept this way? *¿Cuál fue el tiempo más largo que durmió de esta manera?*	Dropdown	0|1 day 1|2-3 days 2|4-7 days 3|Over 1 week	0|Un día 1|2-3 días 2|4-7 días 3|Más de una semana
WERCAP	All	7. Ideas and thoughts have come to me so fast that I could not express them all Las ideas y los pensamientos me han llegado tan rápido que no puedo expresarlos todos	6-point scale	0|No 1|Once 2|Rarely (less than yearly) 3|Sometimes (more than yearly to monthly) 4|Often (more than monthly to weekly) 5|Almost always (more than weekly to daily)	0 |No 1|Una vez 2|Raramente (menos de una vez al año) 3|A veces (más de una vez al año a una vez al mes) 4|A menudo (más de una vez al mes a una vez a la semana) 5|Casi siempre (más de una vez a la semana a una vez al día)
WERCAP	All	8. I have felt that I have great abilities or supernatural powers which no other person in the world has He sentido que tengo grandes habilidades o poderes sobrenaturales que ninguna otra persona en el mundo tiene	6-point scale	0|No 1|Once 2|Rarely (less than yearly) 3|Sometimes (more than yearly to monthly) 4|Often (more than monthly to weekly) 5|Almost always (more than weekly to daily)	0|No 1|Una vez 2|Raramente (menos de una vez al año) 3|Algunas veces (más de una vez al año) 4|A menudo (más de mensual a semanal) 5|Casi siempre (de más de semanal a diario)

SUBSTANCE-INDUCED BIPOLAR BRANCHING—If a user selects a response greater than 0 ("No") on any bipolar frequency item, that same item will display in a panel at the end of the eight bipolar

WERCAP item.

Users respond Yes or No to which item(s) they think may have been experienced due to substances.

Category/ Scale	Audience/ Branching	Question	Question Type	Coded responses
WERCAP	*Any bipolar frequency question > 0*	Do you think drugs or alcohol may have caused you to experience any of the below? ¿Cree que las drogas o el alcohol pueden haberle causado experimentar alguna de las siguientes?	Boolean	1|Yes/Sí 0|No

PSYCHOSIS FUNCTIONING BRANCHING—Selecting a response greater than 0 ("No") on all questions (9a-16a) will display an additional question below for each that assesses functioning.

Please indicate how frequently you experience each item over the past 3 months
Por favor indique con qué frecuencia ha experimentado cada elemento en los últimos 12 meses

Category/ Scale	Audience/ Branching	Question	Question Type	English responses	Spanish responses
WERCAP	All	9a. I have been confused whether something I've experienced is real or imaginary Me ha confundido si algo que he experimentado es real o imaginario	6-point scale	0|No 1|Once 2|Rarely (less than yearly) 3|Sometimes (more than yearly to monthly) 4|Often (more than monthly to weekly) 5|Almost always (more than weekly to daily)	0|No 1|Una vez 2|Raramente (menos de una vez al año) 3|Algunas veces (más de una vez al año a una vez al mes) 4|A menudo (más de una vez al mesa semanal) 5|Casi siempre (más de semanal a diario)
WERCAP	Question 9a > 0	9b. How much did it affect your functioning at home, work or school, or with other people ¿Cuánto afectó su funcionamiento en el hogar, el trabajo o la escuela o con otras personas?	Dropdown	0|Not at all 1|A little 2|Moderately 3|Severely	0|Nada 1|Un poco 2|Moderadamente 3|Severamente

WERCAP	All	10a. I felt my mind was taken over by strange forces that were making me do things I did not choose to do Sentí que fuerzas extrañas se apoderaban de mi mente y me obligaban a hacer cosas que no elegí hacer	6-point scale	0|No 1|Onc e 2|Rarely (less than yearly) 3|Sometimes (more than yearly to monthly) 4|Often (more than monthly to weekly) 5|Almost always (more than weekly to daily)	0|No 1|Una vez 2|Raramente (menos de una vez al año) 3|Algunas veces (más de una vez al año a una vez al mes) 4|A menudo (más de una vez al mesa semanal) 5|Casi siempre (más de semanal a diario)
WERCAP	Questio n 10a > 0	10b. How much did it affect your functioning at home, work or school, or with other people ¿Cuánto afectó su funcionamiento en el hogar, el trabajo o la escuela o con otras personas?	Dropdo wn	0|Not at all 1|A little 2|Moderatel y 3|Severely	0|Nada 1|Un poco 2|Moderadamente 3|Severamente
WERCAP	All	11a. I felt that that some force was putting (or removing) thoughts into (or from) my head Sentí que alguna fuerza estaba poniendo (o quitando) pensamientos en (o de) mi cabeza	6-point scale	0|No 1|Onc e 2|Rarely (less than yearly) 3|Sometimes (more than yearly to monthly) 4|Often (more than monthly to weekly) 5|Almost always (more than weekly to daily)	0|No 1|Una vez 2|Raramente (menos de una vez al año) 3|Algunas veces (más de una vez al año a una vez al mes) 4|A menudo (más de una vez al mesa semanal) 5|Casi siempre (más de semanal a diario)

WERCAP	Question 11a > 0	11b. How much did it affect your functioning at home, work or school, or with other people? ¿Cuánto afectó su funcionamiento en el hogar, el trabajo o la escuela o con otras personas?	Dropdown	0|Not at all 1|A little 2|Moderatel y 3|Severely	0|Nada 1|Un poco 2|Moderadamente 3|Severamente
WERCAP	All	12a. I have thought that people might be able to read my mind or that I can read other people's minds He pensado que la gente podría ser capaz de leer mi mente o que yo puedo leer la mente de otras personas.	6-point scale	0|No 1|Onc e 2|Rarely (less than yearly) 3|Sometimes (more than yearly to monthly) 4|Often (more than monthly to weekly) 5|Almost always (more than weekly to daily)	0|No 1|Una vez 2|Raramente (menos de una vez al año) 3|Algunas veces (más de una vez al año a una vez al mes) 4|A menudo (más de una vez al mesa semanal) 5|Casi siempre (más de semanal a diario)
WERCAP	Question 12a > 0	12b. How much did it affect your functioning at home, work or school, or with other people? ¿Cuánto afectó su funcionamiento en el hogar, el trabajo o la escuela o con otras personas?	Dropdown	0|Not at all 1|A little 2|Moderatel y 3|Severely	0|Nada 1|Un poco 2|Moderadamente 3|Severamente
WERCAP	All	13a. I have thought that some force communicated directly with me by sending special signs that only I could understand He pensado que alguna fuerza	6-point scale	0|No 1|Onc e 2|Rarely (less than yearly) 3|Sometimes (more than yearly to monthly) 4|Often (more than	0|No 1|Una vez 2|Raramente (menos de una vez al año) 3|Algunas veces (más de una vez al año a una vez al mes)

		se comunicaba directamente conmigo enviándome señales especiales que solo yo podía entender		monthly to weekly) 5|Almost always (more than weekly to daily)	4|A menudo (más de una vez al mesa semanal) 5|Casi siempre (más de semanal a diario)
WERCAP	Question 13a > 0	13b. How much did it affect your functioning at home, work or school, or with other people ¿Cuánto afectó su funcionamiento en el hogar, el trabajo o la escuela o con otras personas?	Dropdown	0|Not at all 1|A little 2|Moderatel y 3|Severely	0|Nada 1|Un poco 2|Moderadamente 3|Severamente
WERCAP	All	14a. I have thought that someone is planning to harm me or is following me, when others did not think this was true He pensado que alguien está planeando hacerme daño o me está siguiendo, cuando otros no pensaban que esto era cierto	6-point scale	0|No 1|Onc e 2|Rarely (less than yearly) 3|Sometimes (more than yearly to monthly) 4|Often (more than monthly to weekly) 5|Almost always (more than weekly to daily)	0|No 1|Una vez 2|Raramente (menos de una vez al año) 3|Algunas veces (más de una vez al año a una vez al mes) 4|A menudo (más de una vez al mesa semanal) 5|Casi siempre (más de semanal a diario)
WERCAP	Question 14a > 0	14b. How much did it affect your functioning at home, work or school, or with other people ¿Cuánto afectó su funcionamiento en el hogar, el trabajo o la escuela o con otras personas?	Dropdown	0|Not at all 1|A little 2|Moderatel y 3|Severely	0|Nada 1|Un poco 2|Moderadamente 3|Severamente

WERCAP	All	15a. I have heard a voice or sound that others around me didn't seem to hear Escuché una voz o un sonido que otros a mi alrededor no parecían escuchar.	6-point scale	0|No 1|Onc e 2|Rarely (less than yearly) 3|Sometimes (more than yearly to monthly) 4|Often (more than monthly to weekly) 5|Almost always (more than weekly to daily)	0|No 1|Una vez 2|Raramente (menos de una vez al año) 3|Algunas veces (más de una vez al año a una vez al mes) 4|A menudo (más de una vez al mesa semanal) 5|Casi siempre (más de semanal a diario)
WERCAP	Questio n 15a > 0	15b. How much did it affect your functioning at home, work or school, or with other	Dropdo wn	0|Not at all 1|A little 2|Moderatel y 3|Severely	0|Nada 1|Un poco 2|Moderadamente 3|Severamente

		people? ¿Cuánto afectó su funcionamiento en el hogar, el trabajo o la escuela o con otras personas?			
WERCAP	All	16a. I have seen objects, people or animals that others around me didn't seem to see He visto objetos, personas o animales que otros a mi alrededor no parecían ver	6-point scale	0|No 1|Onc e 2|Rarely (less than yearly) 3|Sometimes (more than yearly to monthly) 4|Often (more than monthly to weekly) 5|Almost always (more than weekly to daily)	0|No 1|Una vez 2|Raramente (menos de una vez al año) 3|Algunas veces (más de una vez al año a una vez al mes) 4|A menudo (más de una vez al mesa semanal) 5|Casi siempre (más de semanal a diario)

WERCAP	Question 16a > 0	16b. How much did it affect your functioning at home, work or school, or with other people *¿Cuánto afectó su funcionamiento en el hogar, el trabajo o la escuela o con otras personas?*	Dropdown	0|Not at all 1|A little 2|Moderately 3|Severely	0|Nada 1|Un poco 2|Moderadamente 3|Severamente

SUBSTANCE-INDUCED PSYCHOSIS BRANCHING—If a user selects a response greater than 0 ("No") on any psychosis frequency item, that same item will display in a panel at the end of the eight psychosis WERCAP item.

Users respond Yes or No to which item(s) they think may have been experienced due to substances.

Category/ Scale	Audience/ Branching	Question	Question Type	Coded responses
WERCAP	*Any psychosis frequency question > 0*	Do you think drugs or alcohol may have caused you to experience any of the below? ¿Cree que las drogas o el alcohol pueden haberle causado experimentar alguna de las siguientes?	Boolean	1|Yes/Sí 0|No

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EATING DISORDERS

Category/ Scale	Audience/ Branching	Question	Question Type	English responses	Spanish responses
SCOFF	All	1. Do you make yourself sick because you feel uncomfortably full? ¿Tiene la sensación de estar enfermo/a porque siente el estómago tan lleno que le resulta incómodo?	Boolean	1|Yes 0|No	1|Sí 0|No
SCOFF	All	2. Do you worry you have lost control over how much you eat? ¿Está preocupado/a porque siente que tiene que controlar cuánto come?			
SCOFF	All	3. Have you recently lost more than one stone (14 lbs or 6.35 kg) in a three-month period? ¿Ha perdido recientemente más de 14 lbs o 6 kgs en un período de tres meses?			
SCOFF	All	4. Do you believe yourself to be fat when others say you are too thin? ¿Cree que está gordo/a aunque otros digan que está demasiado delgado/a?			
SCOFF	All	5. Would you say food dominates your life? ¿Diría que la comida domina su vida?			

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21+ SUBSTANCE USE BRANCHING—Selecting 3 ("21-24 years old") or greater will display the following set of questions related to substance use:

All screener pages related to substance use will display the following page intro: *The following questions ask about using substances like alcohol, drugs, or medications. Please answer them honestly so we can show you the best referrals for your situation. Your answers will be kept private and confidential and will not be shared with Monterey County without your permission.* *Las siguientes preguntas se refieren al uso de sustancias como el alcohol, las drogas o medicaciones. Por favor responda honestamente para que podamos mostrarle las mejores referencias para su situación. Sus respuestas se mantendrán privadas y confidenciales y no se compartirán con el condado de Monterey sin su permiso.*

In the PAST 12 MONTHS, how often have you… En los últimos 12 meses, ¿con qué frecuencia…

Category/ Scale	Audience/ Branching	Question	Question Type	English responses	Spanish responses
TAPS	Age 21 or older	1. Used tobacco or any other nicotine delivery product (i.e., e-cigarette, vaping or chewing tobacco)? Ha utilizado tabaco o otro producto de entrega de nicotina (por ejemplo, cigarrillos electrónicos, vapeo o tabaco para masticar)?	5-point scale	4|Daily or Almost Daily 3|Weekly 2|Monthly 1|Less Than Monthly 0|Never	4|Diario o casi diario 3|Semanal 2|Mensual 1|Menos de una vez al mes 0|Nunca
TAPS	Age 21 or older	2. Had 5 or more drinks (for males)/4 or more drinks (for females) containing alcohol in one day? *One standard drink is about 1 small glass of wine (5 oz), 1 beer (12 oz), or 1 single shot of liquor.* Ha tenido 5 o más bebidas (para hombres)/4 o más bebidas (para mujeres) que contengan alcohol en un día? *Una bebida estándar es aproximadamente 1 vaso pequeño de vino (5 onzas), 1 cerveza (12 oz), o 1 shot ("caballito" o "trago") de licor.*	5-point scale	4|Daily or Almost Daily 3|Weekly 2|Monthly 1|Less Than Monthly 0|Never	4|Diario o casi diario 3|Semanal 2|Mensual 1|Menos de una vez al mes 0|Nunca
TAPS	Age 21 or older	3. Used any drugs including marijuana, cocaine or crack, heroin, methamphetamine (crystal meth), hallucinogens, ecstasy/MDMA? Ha utilizado drogas, como marihuana, cocaína o crack, heroína, metanfetamina (hielo, crystal meth), alucinógenos, Éxtasis/MDMA?	5-point scale	4|Daily or Almost Daily 3|Weekly 2|Monthly 1|Less Than Monthly 0|Never	4|Diario o casi diario 3|Semanal 2|Mensual 1|Menos de una vez al mes 0|Nunca
		4. Used any prescription medications just for the feeling, more than prescribed or			

TAPS	Age 21 or older	that were not prescribed for you? *Prescription medications that may be used this way include: Opiate pain relievers (for example OxyContin, Vicodin, Percocet, Methadone); Medications for anxiety or sleeping (for example Xanax, Ativan, Klonopin); Medications for ADHD (for example Adderall or Ritalin)* Ha utilizado medicamentos recetados sólo para sentir el efecto, más de lo prescrito o que no fueron prescritos para usted? *Medicamentos recetados que pueden ser utilizados de esta manera incluyen: analgésicos opiáceos (por ejemplo, OxyContin, Vicodin, Percocet, Methadone); Medicamentos para la ansiedad o el sueño (por ejemplo, Xanax, Ativan, Klonopin); Medicamentos para el déficit de atención e hiperactividad (por ejemplo, Adderall o Ritalin)*	5-point scale	4|Daily or Almost Daily 3|Weekly 2|Monthly 1|Less Than Monthly 0|Never	4|Diario o casi diario 3|Semanal 2|Mensual 1|Menos de una vez al mes 0|Nunca

21+ SUBSTANCE USE, ADDITIONAL BRANCHING—Selecting 0 ("Never") on question 1 (tobacco) or question 2 (alcohol) will display additional questions to assess use in the past 3 months. From there, there may be more branching questions assessing varying factors such as quantity, if there was a failed attempt to cut back or stop use, or if anyone has expressed concern.

Category/ Scale	Audience/ Branching	Question	Question Type	English responses	Spanish responses

TAPS	Question 1 > 0	5a. In the PAST 3 MONTHS, did you smoke a cigarette containing tobacco or use any other nicotine delivery product (i.e., e-cigarette, vaping or chewing tobacco)? En los últimos 3 meses, ¿fumaste un cigarrillo que contenía tabaco o usaste algún otro producto de entrega de nicotina (por ejemplo, cigarrillo electrónico, vapeo o tabaco para mascar)?	Binary	1|Yes 0|No	1|Sí 0|No
Cigarettes branching intro statement: In the PAST 3 MONTHS... En los últimos 3 meses...					
TAPS	"Yes" to Question 5a	5b. Did you usually smoke more than 10 cigarettes each day, vape, use an e-cigarette or chew tobacco more than 10 times each day? ¿Fumó por lo general más de 10 cigarrillos cada día, vapeó, usó un cigarrillo electrónico o mascó tabaco más de 10 veces al día?	Binary	1|Yes 0|No	1|Sí 0|No
TAPS	"Yes" to Question 5a	5c. Did you usually smoke/use an e-cigarette, vape or chew tobacco within 30 minutes after waking? ¿Fumó/usó un cigarrillo electrónico, vapeó o masticó tabaco generalmente en los primeros 30 minutos después de despertarse?	Binary	1|Yes 0|No	1|Sí 0|No

Category/ Scale	**Audience/ Branching**	**Question**	**Question Type**	**English responses**	**Spanish responses**
TAPS	Question 2 > 0	6a. In the PAST 3 MONTHS, did you have a drink containing alcohol? **One standard drink is about 1 small glass of wine (5 oz), 1 beer (12 oz), or 1 single shot of liquor.* En los últimos 3 meses, ¿tuvo una bebida que contenía alcohol? *Una bebida estándar es aproximadamente 1 vaso pequeño de vino (5 onzas), 1 cerveza (12 oz), o 1 shot ("caballito" o "trago") de licor.*	Binary	1|Yes 0|No	1|Sí 0|No
Alcohol branching intro statement: In the PAST 3 MONTHS... En los últimos 3 meses...					

TAPS	"Yes" to Question 4a	6b. Did you have 4 or more drinks (for females)/5 or more drinks (for males) containing alcohol in a day? ¿Tomó 4 o más bebidas que contenían alcohol en un día?	Binary	1|Yes 0|No	1|Sí 0|No
TAPS	"Yes" to Question 4a	6c. Have you tried and failed to control, cut down or stop drinking? ¿Ha intentado y no ha podido controlar, reducir o detener su uso de alcohol?	Binary	1|Yes 0|No	1|Sí 0|No
TAPS	"Yes" to Question 4a	6d. Has anyone expressed concern about your drinking? ¿Alguien ha expresado preocupación por su consumo de alcohol?	Binary	1|Yes 0|No	1|Sí 0|No

21+ SUBSTANCE USE, ADDITIONAL BRANCHING—Selecting 0 ("Never") on question 3 (drugs) will display additional questions to assess use of different types of drugs in the past 3 months. From there, there may be more branching questions assessing varying factors such as if there was a failed attempt to cut back or stop use or if anyone has expressed concern.

Category/ Scale	Audience/ Branching	Question	Question Type	English responses	Spanish responses
TAPS	Question 3 > 0	7a. In the PAST 3 MONTHS, did you use marijuana (hash, weed)? En los últimos 3 meses, ¿uso marihuana (hash, weed)?	Binary	1|Yes 0|No	1|Sí 0|No
Marijuana branching intro statement: In the PAST 3 MONTHS... En los últimos 3 meses...					
TAPS	"Yes" to Question 5a	7b. Have you had a strong desire or urge to use marijuana at least once a week or more often? ¿Ha tenido un fuerte deseo o impulso de usar marihuana al menos una vez por semana o más a menudo?	Binary	1|Yes 0|N	1|Sí 0|No

				o	
TAPS	"Yes" to Question 5a	7c. Has anyone expressed concern about your use of marijuana? ¿Alguien ha expresado preocupación por su consumo de marihuana?	Binary	1|Yes 0|No	1|Sí 0|No

Category/ Scale	**Audience/ Branching**	**Question**	**Question Type**	**English responses**	**Spanish responses**
TAPS	Question 3 > 0	8a. In the PAST 3 MONTHS, did you use cocaine, crack, or methamphetamine (crystal meth)? En los últimos 3 meses, ¿usó cocaína, crack, o	Binary	1|Yes 0|No	1|Sí 0|No

		metanfetamina (hielo, cristal meth)?			
Cocaine, crack, meth branching intro statement: In the PAST 3 MONTHS... En los últimos 3 meses...					
TAPS	"Yes" to Question 6a	8b. Did you use cocaine, crack, or methamphetamine (crystal meth) at least once a week or more often? ¿Ha utilizado cocaína, crack, o metanfetamina (hielo, cristal meth) por lo menos una vez por semana o más a menudo?	Binary	1|Yes 0|No	1|Sí 0|No
TAPS	"Yes" to Question 6a	8c. Has anyone expressed concern about your use of cocaine, crack, or methamphetamine (crystal meth)? ¿Alguien ha expresado preocupación por su consumo de cocaína, crack, o metanfetamina (hielo, cristal meth)?	Binary	1|Yes 0|No	1|Sí 0|No

Category/ Scale	**Audience/ Branching**	**Question**	**Question Type**	**English responses**	**Spanish responses**
TAPS	Question 3 > 0	9a. In the PAST 3 MONTHS, did you use heroin? En los últimos 3 meses, ¿usó heroína?	Binary	1|Yes 0|No	1|Sí 0|No
Heroin branching intro statement: In the PAST 3 MONTHS... En los últimos 3 meses...					
TAPS	"Yes" to Question 7a	9b. In the PAST 3 MONTHS, have you tried and failed to control, cut down or stop using heroin? ¿Ha intentado y no ha podido controlar, reducir o dejar de usar heroína?	Binary	1|Yes 0|No	1|Sí 0|No
TAPS	"Yes" to Question 7a	9c. In the PAST 3 MONTHS, has anyone expressed concern about your use of heroin? ¿Alguien ha expresado preocupación por su consumo de heroína?	Binary	1|Yes 0|No	1|Sí 0|No

21+ SUBSTANCE USE, ADDITIONAL BRANCHING—Selecting 0 ("Never") on question 4 (prescription meds) will display additional questions to

assess use of different types of prescription meds in the past 3 months. From there, there may be more branching questions assessing varying factors such as if there was a failed attempt to cut back or stop use or if anyone has expressed concern.

Category/ Scale	Audience/ Branching	Question	Question Type	English responses	Spanish responses
TAPS	Question 4 > 0	10a. In the PAST 3 MONTHS, did you use a prescription opiate pain reliever (for example, Percocet, Vicodin) not as prescribed or that was not prescribed for you? En los últimos 3 meses, ¿ha utilizado un analgésico opiáceo prescrito (por ejemplo, Percocet, Vicodina), de una manera que no fue prescrita o un analgésico opiáceo	Binary	1|Yes 0|No	1|Sí 0|No

		que no le prescribieron?			
Opioid branching intro statement: In the PAST 3 MONTHS... En los últimos 3 meses...					
TAPS	"Yes" to Question 8a	10b. In the PAST 3 MONTHS, have you tried and failed to control, cut down or stop using an opiate pain reliever? ¿Ha intentado y no ha podido controlar, reducir o dejar de usar un analgésico opiáceo?	Binary	1|Yes 0|No	1|Sí 0|No
TAPS	"Yes" to Question 8a	10c. In the PAST 3 MONTHS, has anyone expressed concern about your use of an opiate pain reliever? ¿Alguien ha expresado preocupación por su consumo de un analgésico opiáceo?	Binary	1|Yes 0|No	1|Sí 0|No

Category/ Scale	**Audience/ Branching**	**Question**	**Question Type**	**English responses**	**Spanish responses**
TAPS	Question 4 > 0	11a. In the PAST 3 MONTHS, did you use a medication for anxiety or sleep (for example, Xanax, Ativan, or Klonopin) not as prescribed or that was not prescribed for you? En los últimos 3 meses, ¿ha utilizado un medicamento para la ansiedad o el sueño (por ejemplo, Xanax, Ativan, o Klonopin) de una manera que no fue prescrita o un medicamento para la ansiedad o el sueño que no le prescribieron?	Binary	1|Yes 0|No	1|Sí 0|No
Anxiety or sleep medications branching intro statement: In the PAST 3 MONTHS... En los últimos 3 meses...					
TAPS	"Yes" to Question 9a	11b. In the PAST 3 MONTHS, have you had a strong desire or urge to use medications for anxiety or sleep at least once a week or more often? ¿Ha tenido un fuerte deseo o impulso de usar medicamentos para la ansiedad o el sueño por lo menos una vez por semana o más a menudo?	Binary	1|Yes 0|No	1|Sí 0|No

TAPS	"Yes" to Question 9a	11c. In the PAST 3 MONTHS, has anyone expressed concern about your use of medication for anxiety or sleep? ¿Alguien ha expresado preocupación por su consumo de medicamentos para la ansiedad o el sueño?	Binary	1|Yes 0|No	1|Sí 0|No

Category/ Scale	**Audience/ Branching**	**Question**	**Question Type**	**English responses**	**Spanish responses**
TAPS	Question 4 > 0	12a. In the PAST 3 MONTHS, did you use a medication for ADHD (for example, Adderall, Ritalin) not as prescribed or that was not prescribed for you? En los últimos 3 meses, ¿ha utilizado un medicamento para el déficit de atención e hiperactividad (por ejemplo,	Binary	1|Yes 0|No	1|Sí 0|No
		Adderall, Ritalin) de una manera que no fue prescrita o un medicamento para el déficit de atención e hiperactividad que no le prescribieron?			
ADHD medications branching intro statement: In the PAST 3 MONTHS... En los últimos 3 meses...					
TAPS	"Yes" to Question 10a	12b. In the PAST 3 MONTHS, did you use a medication for ADHD (for example, Adderall, Ritalin) at least once a week or more often? ¿Ha utilizado un medicamento para el déficit de atención e hiperactividad (por ejemplo, Adderall, Ritalin) por lo menos una vez por semana o más a menudo?	Binary	1|Yes 0|No	1|Sí 0|No
TAPS	"Yes" to Question 10a	12c. In the PAST 3 MONTHS, has anyone expressed concern about your use of a medication for ADHD (for example, Adderall or Ritalin)? ¿Alguien ha expresado preocupación por su consumo de medicamentos para el "déficit de atención e hiperactividad" (por ejemplo, Adderall o Ritalin)?	Binary	1|Yes 0|No	1|Sí 0|No

NOTE: The last question of TAPS asks about use of any other illegal or recreational drug. It

is not part of the first four TAPS question branching and all users 21+ will be asked 13a.

Category/ Scale	Audience/ Branching	Question	Question Type	English responses	Spanish responses
TAPS	All	13a. In the PAST 3 MONTHS, did you use any other illegal or recreational drug (for example, ecstasy/molly, GHB, poppers, LSD, mushrooms, special K, bath salts, synthetic marijuana ('spice'),whip-its, etc.)? En los últimos 3 meses, ¿ha utilizado alguna otra droga ilegal o recreativa (por ejemplo, el éxtasis/Molly, GHB, Poppers, LSD, hongos, special K, sales de baño ('bath salts'), marihuana sintética ('Spice '), K2, whip-its, etc.)?	Binary	1|Yes 0|No	1|Sí 0|No
TAPS	"Yes" to Question 11a	13b. In the PAST 3 MONTHS, what were the other drug(s) you used? En los últimos 3 meses, ¿cuáles fueron las otras drogas que utilizó?	Short answer (text)		

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<21-YEARS-OLD SUBSTANCE USE BRANCHING—Selecting 2 ("18-20 years old") or less will display the following set of questions related to substance use:

During the PAST 12 MONTHS, on how many days did you… Durante los ÚLTIMOS 12 MESES, cuántos días…

Category/ Scale	Audience/ Branching	Question	Question Type
CRAFFT 2.1+N	Under 21	1. Drink more than a few sips of beer, wine, or any drink containing alcohol? Choose “0” if none. ¿Has bebido algo más que unos sorbos de cerveza, vino o alguna bebida con alcohol? Di “0” si ninguno.	Dropdown list from 0-9 and then "10 or more days" option
CRAFFT 2.1+N	Under 21	2. Use any marijuana (weed, oil, or hash, by smoking, vaping, or in food) or “synthetic marijuana” (like “K2,” “Spice”) or “vaping” THC oil? Choose “0” if none. ¿Has usado algún tipo de marihuana (cannabis, aceite, cera, para fumar, vaporizar, fumar dosis muy concentradas o “dabs” o en los alimentos) o “marihuana sintética” (como “K2”, “Spice”)? Di “0” si ninguno.	Dropdown list from 0-9 and then "10 or more days" option
CRAFFT 2.1+N	Under 21	3. Use anything else to get high (like other illegal drugs, prescription or over-the-counter medications, and things that you sniff, huff, or vape)? Choose “0” if none. ¿Has usado algo más para drogarte (como otras drogas ilegales, medicamentos recetados o de venta libre, y cosas para inhalar, esnifar, vaporizar o inyectarse)? Di “0” si la respuesta es ninguno.	Dropdown list from 0-9 and then "10 or more days" option
CRAFFT 2.1+N	Under 21	4. Use a vaping device* containing nicotine and/or flavors, or use any tobacco products**? Choose “0” if none. *Such as e-cigs, mods, pod devices like JUUL, disposable vapes like Puff Bar, vape pens, or e-hookahs. **Cigarettes, cigars, cigarillos, hookahs, chewing tobacco, snuff, snus, dissolvables, or nicotine pouches. ¿Has usado un dispositivo vaporizador* que contiene nicotina o sabores, o algún producto de tabaco**? Di “0” si la respuesta es ninguno. *Como cigarrillos electrónicos, “mods”, dispositivos “pod” como JUUL, vaporizadores descartables como Puff Bar, vaporizadores tipo bolígrafo o pipas de agua electrónicas. **Pitillos, cigarros, cigarrillos, pipas, tabaco de mascar, tabaco rapé, “snus” o solubles.	Dropdown list from 0-9 and then "10 or more days" option

CRAFFT 2.1+N	Under 21	5. Have you ever ridden in a CAR driven by someone (including yourself) who was “high” or had been using alcohol or drugs? ¿Alguna vez has viajado en un vehículo (CAR) conducido por alguien (incluido/a tú mismo/a) que estaba drogado o que había consumido alcohol o drogas?	Boolean

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<21-YEARS-OLD SUBSTANCE USE, ADDITIONAL BRANCHING—Typing in a number greater than 0 in the short answer fields for questions 1-3 will display additional questions related to alcohol and drug use. Typing in a number greater than 0 in the short answer fields for question 4 will display additional questions related to nicotine use.

Category/ Scale	Audience/ Branching	Question	Question Type	English responses	Spanish responses
CRAFFT 2.1+N	>0 for Questions 1-3	6. Do you ever use alcohol or drugs to RELAX, feel better about yourself, or fit in? ¿Alguna vez consumes alcohol o drogas para relajarte, sentirte mejor contigo mismo/a o integrarte en un grupo?	Binary	0|No 1|Yes	0|No 1|Sí
CRAFFT 2.1+N	>0 for Questions 1-3	7. Do you ever use alcohol or drugs while you are by yourself, or ALONE? ¿Alguna vez consumes alcohol o drogas cuando estás solo/a o sin compañía?	Binary	0|No 1|Yes	0|No 1|Sí
CRAFFT 2.1+N	>0 for Questions 1-3	8. Do you ever FORGET things you did while using alcohol or drugs? ¿Alguna vez te olvidas de cosas que has hecho mientras consumías alcohol o drogas?	Binary	0|No 1|Yes	0|No 1|Sí
CRAFFT 2.1+N	>0 for Questions 1-3	9. Do your FAMILY or FRIENDS ever tell you that you should cut down on your drinking or drug use? ¿Tus familiares o amigos alguna vez te dicen que deberías disminuir el consumo de alcohol o drogas?	Binary	0|No 1|Yes	0|No 1|Sí
CRAFFT 2.1+N	>0 for Questions 1-3	10. Have you ever gotten into TROUBLE while you were using alcohol or drugs? ¿Alguna vez te has metido en problemas al consumir alcohol o drogas?	Binary	0|No 1|Yes	0|No 1|Sí

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The following questions ask about your use of any vaping devices containing nicotine and/or flavors, or use of any tobacco products.

Las siguientes preguntas son sobre el uso de dispositivos vaporizadores que contienen nicotina o sabores, o sobre el uso de productos de tabaco.

Category/ Scale	Audience/ Branching	Question	Question Type	English responses	Spanish responses
CRAFFT 2.1+N	>0 for Question 4	11. Have you ever tried to quit using, but couldn't? ¿Alguna vez has intentado DEJAR de consumir, pero no pudiste?	Binary	0|No 1|Yes	0|No 1|Sí
CRAFFT 2.1+N	>0 for Question 4	2. Do you vape or use tobacco now because it is really hard to quit? ¿ACTUALMENTE usas vaporizador o tabaco porque te resulta muy difícil dejar de consumir?	Binary	0|No 1|Yes	0|No 1|Sí
CRAFFT 2.1+N	>0 for Question 4	3. Have you ever felt like you were addicted to vaping or tobacco? ¿Alguna vez has sentido que eres ADICTO/A al vaporizador o al tabaco?	Binary	0|No 1|Yes	0|No 1|Sí
CRAFFT 2.1+N	>0 for Question 4	4. Do you ever have strong cravings to vape or use tobacco? ¿Alguna vez sientes muchas GANAS de usar vaporizador o tabaco?	Binary	0|No 1|Yes	0|No 1|Sí
CRAFFT 2.1+N	>0 for Question 4	5. Have you ever felt like you really needed to vape or use tobacco? ¿Alguna vez sientes muchas GANAS de usar vaporizador o tabaco?	Binary	0|No 1|Yes	0|No 1|Sí
CRAFFT 2.1+N	>0 for Question 4	6. Is it hard to keep from vaping or using tobacco in places where you are not supposed to, like school? ¿Te resulta difícil evitar usar vaporizador o tabaco en LUGARES donde supuestamente no debes hacerlo, como la escuela?	Binary	0|No 1|Yes	0|No 1|Sí

When you haven't vaped or used tobacco in a while (or when you tried to stop using)...

Cuando NO HAS USADO vaporizador o tabaco durante un tiempo (o cuando has intentado dejar de usarlo)...

Category/ Scale	Audience/ Branching	Question	Question Type	English responses	Spanish responses
CRAFFT 2.1+N	>0 for Question 4	7a. Did you find it hard to concentrate because you couldn't vape or use tobacco? ¿Te resultó difícil CONCENTRARTE porque no podías usar vaporizador o tabaco?	4x2 Matrix	0|No 1|Yes	0|No 1|Sí
		7b. Did you feel more irritable because you couldn't vape or use tobacco? ¿Te sentiste más IRRITABLE porque no podías usar vaporizador o tabaco?			
		7c. Did you feel a strong need or urge to vape or use tobacco? ¿Sentiste NECESIDAD o ganas intensas de usar vaporizador o tabaco?			
		7d. Did you feel nervous, restless, or anxious because you couldn't vape or use tobacco? ¿Te sentiste NERVIOSO/A, inquieto/a o ansioso/a porque no podías usar vaporizador o tabaco?			

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The next questions ask about you and your experiences. Why is this important? We use the information you provide to refer you to the best resources and services for you.
Las siguientes preguntas se refieren a usted y sus experiencias. ¿Por qué es importante? Usamos la información que usted provee para referirle los mejores recursos y servicios.

Category/ Scale	Audience/ Branching	Question	Question Type	English responses	Spanish responses
Demographic	All	Are you currently receiving treatment or services for mental health or substance use? ¿Actualmente recibe tratamiento o servicios por salud mental o uso de sustancias?	Boolean	1|Yes 0|No	1|Sí 0|No
Demographic	All	Are you currently taking any medications for mental health or substance use? ¿Actualmente está tomando algún medicamento para la salud mental o el uso de sustancias?	Boolean	1|Yes 0|No	1|Sí 0|No
Demographic	All	Are you currently receiving services or have you ever received services from Monterey County Behavioral Health? ¿Recibe actualmente servicios o alguna vez ha recibido servicios de Salud conductual del condado de Monterey?	Boolean	1|Yes 0|No	1|Sí 0|No
				0|Housing (like homelessness, being able to pay rent, or being able to stay in your current home) 1|Physical health	0|Vivienda (falta de vivienda, pagar renta o poder permanecer en vivienda actual) 1|Salud física (enfermedad

Demographic	All	Are you currently having any significant challenges with the following items? Please check all that apply. ¿Actualmente tiene algún desafío significativo con los siguientes elementos? Por favor marque todos los que apliquen.	Checklist	(like chronic illness, pain, or disability) 2|Job/employment (like unemployment, finding a job, or keeping a job) 3|School (like missing school, being late to school, or maintaining good grades)	crónica, dolor o discapacidad) 2|Trabajo/empleo (desempleo, encontrar trabajo o mantener un trabajo) 3|Escuela (faltar a la escuela, llegar tarde a la escuela o mantener buenas calificaciones) 4|Seguridad alimentaria (poder
				4|Food insecurity (like being able to pay for food or having access to healthy food options) 5|Transportation 6|Immigration 7|Family instability 8|None of the above	pagar alimentos o tener acceso a opciones de alimentos saludables) 5|Transporte 6|Inmigración 7|Inestabilidad familiar 7|Ninguna de las anteriores

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The next questions ask about you and your experiences. Why is this important? We use the information you provide to refer you to the best resources and services for you.

Las siguientes preguntas se refieren a usted y sus experiencias. ¿Por qué es importante? Usamos la información que proporcionamos para referirse a los mejores recursos y servicios para usted.

Category/ Scale	**Audience/ Branching**	**Question**	**Question Type**	**English responses**	***Spanish responses***
Demographic	All	What is your zip code? ¿Cuál es su código postal?	Short answer (numeric)		

Demographic	All	Are you of Hispanic, Latino, or of Spanish origin? ¿Es usted de origen hispano, latino o español?	Binary	1|Yes 0|No	1|Sí 0|No
Demographic	All	What race do you identify with? Please check all that apply. ¿Con qué raza se identifica? Por favor marque todos los que apliquen.	Checklist	0|Indigenous, American Indian, or Alaska Native 1|Asian 2|Black 3|Native Hawaiian or Other Pacific Islander 4|White 0ther race	0|Indígena, Indio/a Americano/a o Nativo/a de Alaska 1|Asiático/a 2|Negro/a 3|Hawaiano/a Nativo/a o de otras Islas del Pacífico 4|Blanco /a Otra raza
Demographic	All	What is your language of preference? ¿Cuál es su idioma de preferencia?	Multiple choice	0|English 1|Spanish 2|Indigenous languages (e.g. Mixteco, Triqui, Chatino) Other language	0|Inglés 1|Español 2|Lenguas indígenas (por ejemplo: Mixteco, Triqui, Chatino) Otro idioma o lengua

Demographic	All	Are you involved with any of the following? Please check all that apply. ¿Está involucrado con alguno de los siguientes? Por favor marque todos los que apliquen.	Checklist	0|Foster care or child welfare services 1|The justice system 2|CalWORKS 3|Cal Fresh 4|Other open case with the Department of Social Services 5|None of the above	0|Servicios de orfanato o de bienestar infantil 1|El sistema de justicia 2|CalWORKS 3|Cal Fresh 4|Otro caso abierto con el Departamento de Servicios Sociales 5|Ninguna de las anteriores

Demographic	All	What health insurance do you have? Please check all that apply. ¿Qué seguro de salud tiene? Por favor marque todos los que apliquen.	Checklist	0|Medi-Cal or Medicaid 1|Medicare 2|Private insurance (either from your job, through Covered California, or as a dependent on someone else's insurance) 3|No insurance Other insurance	0|Medi-Cal o Medicaid 1|Medicare 2|Seguro privado (ya sea de su trabajo, a través de Covered California o como dependiente del seguro de otra persona) 3|Sin seguro Otro seguro de salud
Demographic	All	How did you find out about this mental health questionnaire? Please check all that apply. *MCBH = Monterey County Behavioral Health* ¿Cómo se enteró de este cuestionario de salud mental? Por favor marque todos los que apliquen. *MCBH = Monterey County Behavioral Health*	Checklist	0|A provider, counselor, or therapist who works for MCBH 1|A mental health or substance use provider who does not work for MCBH 2|Social media 3|The Monterey County website 4|An advertisement, flyer, or billboard in the community 5|Friend or family member 6|My primary care physician or other doctor or nurse 7|School or work Other (describe)	0|Un médico/a, consejero/a o terapeuta que trabaja para MCBH 1|Un médico/a de salud mental o consumo de sustancias, que no trabaja para MCBH 2|Redes sociales 3|El sitio del Condado de Monterey 4|Un anuncio, volante o valla publicitaria en la comunidad 5|Amigo/a o familiar 6|Mi médico de atención primaria u otro médico o enfermera 7|Escuela o trabajo Otro

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