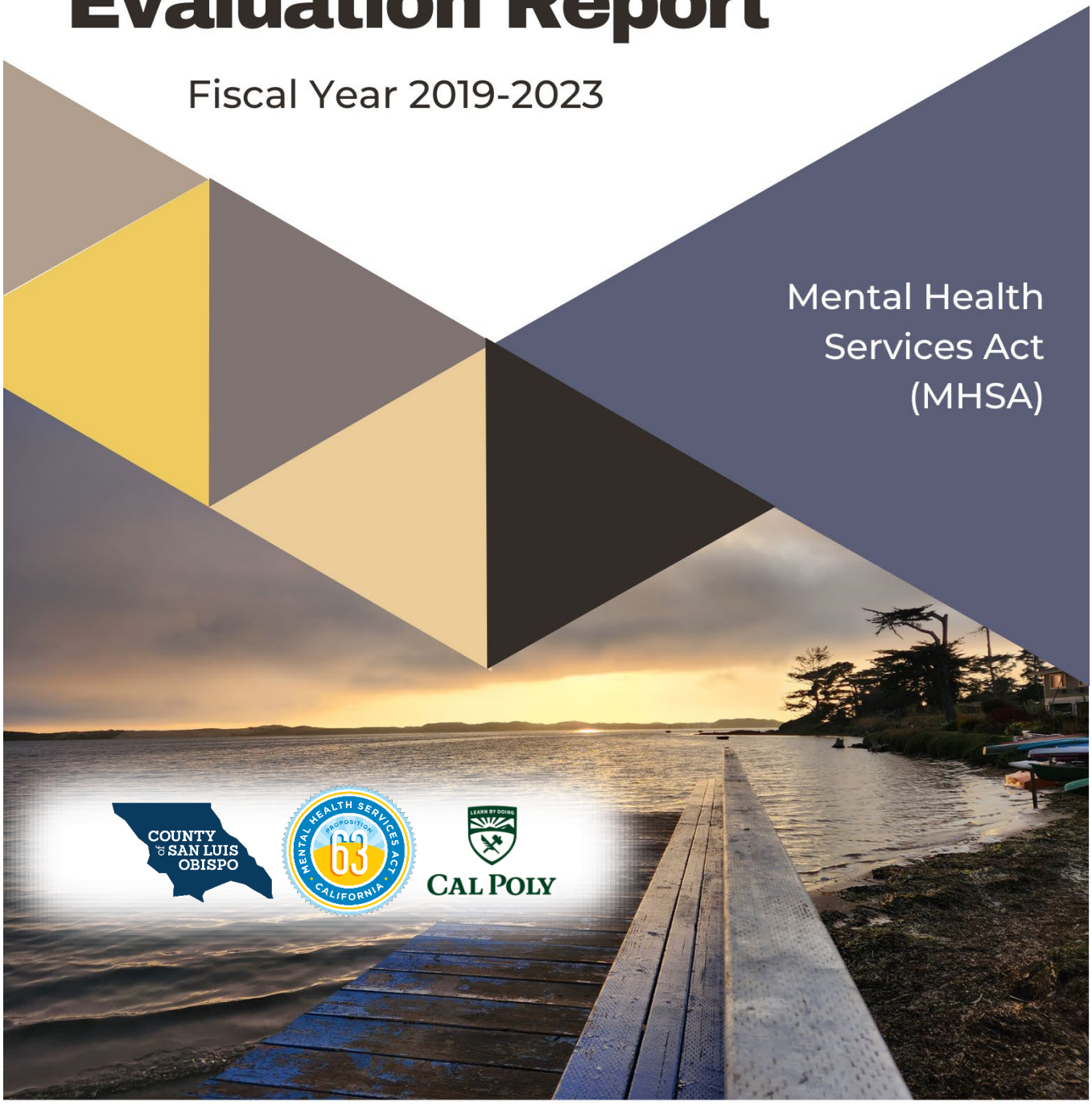
County of San Luis Obispo
Behavioral Health Department

Innovation Projects Evaluation Report

Fiscal Year 2019-2023

Mental Health Services Act (MHSA)



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Letter to Reader

COUNTY OF SAN LUIS OBISPO HEALTH AGENCY BEHAVIORAL HEALTH DEPARTMENT
Mental Health Services Act
Star Graber, PhD, LMFT Behavioral Health Director
Frank Warren, M.P.P, C.P.M. MHSA Coordinator

December, 2023

It is with great pride and excitement that the County of San Luis Obispo's Behavioral Health Department present this evaluation of Mental Health Services Act (MHSA)-funded Innovation programs for the fiscal years of 2019-2023. The data analysis has been conducted by faculty and students from the Master of Public Policy program at California Polytechnic State University (Cal Poly) in collaboration with the San Luis Obispo Behavioral Health Department (SLO BHD).

"Innovation" is the most unique of MHSA *components*, offering counties the opportunity to work with their communities and develop new, original, best practices for the public mental health system. An Innovation project is designed mainly to contribute to learning, rather than simply providing a service. It was fitting, then, for SLO County to partner with a local institution of higher education to examine the efficacy and results of these two projects.

Along with our gratitude for Cal Poly and its MPP program for their efforts and collaboration with these projects, SLO County would also like to thank Nestor Veloz-Passalacqua, Timothy Siler, and Landon King who served as the County's Innovation Coordinators during the planning, implementation, operations, and completion stages of these projects.

Thank you for your interest in the County's Innovation projects for 2019-2023!

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Executive Summary

The Mental Health Services Act (MHSA) was enacted in November of 2004 with the passage of Proposition 63 by California voters. The implementation of MSHA saw the creation of new regional mental health service initiatives, known as "INNovation Projects" that are administered by county governments and financed by the MHSA. In the years since the Act's passage, a broad array of community health projects gained shape, and many have become important nodes within the mental healthcare networks of their respective counties. Due to the experimental nature of these programs, third-party evaluations were required to offer insights into the efficacy of different treatment models. Such independent evaluations may help improve efficiency, efficacy, and appropriate dispersion of innovation programs.
The County of San Luis Obispo's Behavioral Health Department (SLOBHD) is excited to put forth this plan to utilize Mental Health Services Act (MHSA) Innovation (INN) component funds to test new methods to serve and engage the community mental health field. The goal of the proposed Innovation projects is to build capacity within the community by learning new and adapted models for promoting positive mental health and reducing the negative impact of mental illness and stigma.

Over an 8–10-month period from 2018-2019, the SLOBHD worked collaboratively with community advisors, including consumers of mental health services and family members, to develop the County's INN Plan. The plan consisted of two new and novel mental health approaches to informing the County and the community on possible improvements for addressing mental health disparities. During the community selection process, the two chosen projects were coincidently both aimed at improving overall health, climate, and physical and emotional safety for youth in SLO County schools. During the evaluation stage for this round of Innovation, the two project facilitators recognized the interconnectivity of each other's projects and laid a foundation for future collaborations.

The total cost of the two projects, including administrative services, was approximately $1.5 million over 4 years. The projects were funded with the County's MHSA funds that were allocated by the state specifically for INN projects. The table below depicts the budgets for each project and the total for the 4-year-round of funding.

INN Project Budgets	FY 19-20	FY 20-21	FY 21-22	FY 22-23	Total
Holistic Adolescent Health	$135,000	$182,500	$182,500	$160,000	**$660,000**

B-HARP	$218,282	$216,862	$215,922	$228,864.40	**$879,930.40**
TOTAL INN Budget	**$353,282**	**$399,362**	**$398,422**	**$388,864.40**	**$1,539,930.40**

This report examines the research model and results of two projects that launched in 2019. Each project was subject to a series of approvals by community advisory committees, the SLO County Behavioral Health Board, the SLO County Board of Supervisors, and the state appointed Mental Health Services Oversight and Accountability Commission (MHSOAC) for processing and regulating INN project proposals. The agencies that facilitated the Innovation projects were selected through a Request for Proposals (RFP) process in 2018.

The timelines for each project consisted of 6 months for planning and set-up, 3 years of testing and operations, and another 6 months for ramp-down and evaluation. SLOBHD contracted with the local university's Master of Public Policy department to assist with project evaluation. The Cal Poly Innovation Evaluators (herein known as CIE) collected data and conducted statistical analysis for each project. The evaluations will identify and analyze the following key components of an Innovation project as required by MHSA:

1) Summary of the priority issue related to mental illness or a change in the current mental health service system.
2) Changes made to the project during operations, reasons for changes, and the impact on timeline and results.
3) Final evaluation results
    a. Description of methodology;
    b. Outcomes related to the new or changed approach to mental health;
    c. Variation in outcomes based on demographic data;
    d. Assessment of which activities or elements contributed to successful outcomes;
    e. Explanation of cultural competency within project and evaluation;
    f. Explanation of community contribution and collaboration.
4) Future plans for the project including the County's continued role in funding or otherwise.
5) Analysis of outcomes in relation to the proposed goals, and lessons learned.

The Behavioral Health Assessment and Response Project (B-HARP)

The B-HARP Innovation was developed to address the lack of a coordinated and collaborative model and system to assess and intervene as necessary with school-based threats of violence. The project was designed to coordinate and implement a training model and system to learn, assess, and intervene when cases of threat become apparent or imminent. The components of the project include examining diverse approaches to threat assessment and creating protocols to identify and manage threats; testing a system of collaboration and trained experts to implement a multi-disciplinary team model with a common language that would allow for expedient and clear communication; and executing trainings that would educate students, parents, school staff, law enforcement, city officials, and local mental health professionals on warning behaviors and the community-based approach for intervention and treatment. The research objectives were to examine four outcomes of the threat assessment training model:

1. Increase and maintain threat assessment knowledge.
2. Community design of threat assessment of best practice model. Increase community collaboration and utilization of threat assessment skills.
3. Educate school/campus staff, students, and parents about behaviors of concerns (Warning Signs).
4. Increase the knowledge of mental health professionals of threat assessment professionals. Increase community capacity to provide mental health intervention.

B-HARP executed 27 training courses for teachers, school administrators, guidance counselors, local mental health professionals, law enforcement, and parents. The system was also implemented in nine distinct case reviews to apply the collaborative model in real-world settings.

The results from the training courses included:

- 23% increase in participants' understanding of their role in the school threat assessment process.
- 17% increase in participants' understanding of their school's process once a concerning behavior was reported.
- 30% improvement on average scores of threat assessment knowledge quiz administered prior to and after the training.

The Holistic Adolescent Health (HAH) Project

The HAH project aimed to examine the impact of a coordinated school-based health curriculum that would provide high school students with a comprehensive mental, physical, and social health education in SLO County. Community Action Partnership of San Luis Obispo (CAPSLO), in collaboration with local schools, determined that the current compartmentalized curricula limited the ability of youth to attain a whole person/holistic view of health while balancing the inter-related aspects of mental, physical, and social health engagement processes. Research concluded that students were reporting greater struggles to cope with overwhelming stress and anxiety. School officials and staff have requested resources on how to help teens develop coping skills in the currently overcharged social environment.

The project implemented a comprehensive approach to mental, physical, and social health with the addition of a mindfulness skill-building component to the existing high school health curriculum. The objective was to enhance the ability of adolescents to make positive life choices related to their own health and well-being while encouraging them to take ownership and proactively manage their own health and well-being. The HAH project developed and deployed a unique curriculum and health education delivery model which integrated training on mindfulness skills into the existing health education provided at two SLO County High Schools. This Innovation posited that better physical and social-emotional health outcomes can be achieved through the implementation of this new curriculum and delivery model that included: 1) 15 sessions of in-class mindfulness skills and knowledge curriculum, and 2) one-on-one coaching and follow-up with youth.

Results of the HAH project include:

- Completing the classroom course resulted in a statistically significant improvement in knowledge of mindfulness practices and other health focused curricula associated with healthy decision making for mental, physical, and sexual well-being.
- Nearly all students (96%) that participated in one-on-one coaching reported that they would be comfortable speaking with a parent or guardian about sex, reproduction, and birth control compared to 39% of students reporting comfortability with these conversations prior to both in-class and one-on-one coaching.

The Behavioral Health Assessment & Response Project (B-HARP)

PROJECT OVERVIEW

The Behavioral Health Assessment and Response Project (B-HARP) aimed to educate and train teachers, school administrators, school guidance counselors, city officials, mental healthcare providers, local law enforcement, and community members around the issues of threats in schools. Through this training, B-HARP sought to test a model of effective response by increasing the efficiency of communication and knowledge of the process that would be both collaborative and highly coordinated. The goal of the training was to advance the knowledge to identify threats and navigate the threat assessment process, while building the confidence, skills, and connectivity between the individuals involved in the process.

BACKGROUND

PURPOSE & COMMUNITY NEED

San Luis Obispo County lacks a coordinated and collaborative training model and system to assess and intervene as necessary with school-based threats. In 2014, the FBI released A Study of Active Shooter Incidents in the United States Between 2000 and 2013, which reviewed 160 incidents involving an individual who attempted to kill people in a confined/populated area. Only twelve incidents, or 7.5%, occurred at institutions of higher education; however, nearly one quarter of the incidents studied occurred at educational settings and these accounted for some of the highest casualty counts. The individuals who engaged in violence included students, former students, employees, and a visitor (Blair & Schweit, 2014). The report also contains information regarding incidents occurring at commerce and employment settings, which may have relevant findings for the San Luis Obispo community.

The Center for Homeland Defense and Security's K-12 School Shooter data base (www.chds.us) indicates that in 2018, there have been 92 school shooting incidents, double the number of incidents for 2016 and 2017, with the most frequent ages of the perpetrator has been 16 and 17 years. Thus, incidents, nationally, are increasing. More recently, there have been incidents that have occurred locally and regionally. These have included the following incidents as captured by headlines:

1. A 17-year-old Morro Bay High School student was arrested this week on suspicion of making threats against the school, police say. March 26th, 2018.
2. Atascadero High student threatened to 'shoot up' school. March 14th, 2018.

3. Islay Vista Mass Murder, May 23, 2014.
4. Individual in mental health therapy makes a threat toward Ventura Schools.
5. Borderline Bar and Grill Shooting, Thousand Oaks, CA November 7th, 2018.

Although threat assessments and monitoring have become a staple practice in educational institutions, recent case study reviews have noted that isolated, inconsistent, and ineffective implementation of threat assessment and monitoring can leave educational institutions vulnerable to violent incidents (Goodrum et. al 2018, White 2017). With the increasing, ongoing threats and lack of a coordinated and collaborative model system, San Luis Obispo County is at a disadvantage to assess and engage youth in these situations.

Presently, none of the educational, law enforcement, or educational institutions have a regular database that monitors the number of threats made, whether low level or of higher level, type of threat, and by whom, that warrants a multi-agency response. San Luis Coastal Unified School District provided the following information based upon a review of threat assessment reports from the past several years. These cases are frequencies and presented in a range as each year may differ.

High Level Threats	*Requiring Multi-Agency Response*	*Requiring Mobile Crisis or Hospitalization*	*Amount of Staff Time Paperwork and Follow-up*	*Ongoing Monitoring*
9-12 per year	*2-4 per year*	*2-3 per year*	*2-3 weeks*	*2 months*

It should also be noted that there have been several cases in the last 5 years that have required multi-agency involvement with one including FBI involvement involving a student and parent.

Community Collaboration

The first Innovation Community Advisor meeting for this round took place on October 11, 2018 where new and current Innovation Community advisors were present to review the Innovation guidelines and begin a larger conversation and collaboration process for research and testing new meaningful ideas in our community. Community members included educators, mental health providers, community-based organization partners, and other interested individuals. The County made available information containing steps to successfully submit an innovation idea, along with providing technical assistance in developing the narrative for the proposal. A local psychologist, Dr. Joseph Holifield, proposed the concept that would eventually become the B-HARP Project. At the initial meeting, he presented

the first iteration of his idea to integrate and develop a unique coordinated and collaborative training model and system to learn, assess, and intervene when threats become apparent or imminent in the educational system. Dr. Holifield had based his idea from years of performing threat assessments and leading threat assessment teams in several local school districts (2000-2017). He blended his experience with new information about community-based models presented at a recent Threat Assessment Conference. Dr. Holifield had also taught at Cal Poly for 15 years (2000-2015) and school shootings were a topic covered in his lectures. During this time, he began to reach out to community partners, law enforcement, and mental health professionals to collaborate on a potential threat assessment program. Having practiced in the San Luis Obispo community for 19 years, he understood the current limitations in the community regarding mental health support for individuals who present with these issues.

The threat assessment project became part of a larger collaboration between local organizations around the creation of a coordinated and collaborative training system and model to best approach, treat, assess situations threat in our community. The concept continued to be refined as County staff, Dr. Holifield, California Polytechnic State University, and school district representatives were involved. The project design is the result of community engagement with local school districts led by Dr. Joseph Holifield. Additionally, the Behavioral Health Department has provided support in the form of technical assistance to best refine and coordinate efforts to make the proposal a priority in reference to what the community needs are. Added interest in implementation and processes came from California Polytechnic State University – San Luis Obispo. The project design became apparent as feedback included the need to build a training system and infrastructure to allow for better engagement and response to threats that are present in the community, leading to assist youth and college students being connected to mental health services and a recovery process before a threat is made present. The County provided technical assistance and support in the development of the proposal, as well as providing procedural information and guiding the project through the local and state approval processes.

Memorandums of Understanding (MOU's)

Originally, this organization operated from an MOU that was templated based upon the Salem-Keizer Cascade Model provided by John Van Dreal. This was reviewed at the Community Partner's Meeting in December of 2020. An original unsigned example of this MOU was provided to SLOBHS MHSA in the FY 2020-21 Annual Report. In FY 21-22, this templated MOU was rewritten and sent for feedback to the

community partners participating in the grant. No major changes were suggested. This was the anticipated implementation year, yet the Omicron variant of COVID-19 impacted school and agencies. The issue of onboarding a Level 2 Consultation Team Meetings and referral processes. With the revised Level 2 Pilot Protocol which will be incorporated into the FY 22-23 MOUs with school districts.

During the FY 21-22 review, the Level 2 meeting shifted to discussion and consultation of actual student behaviors and cases from community partners. A by-product of this cross-hybridization was the creation of a Level 2 protocol and process incorporating language from both approaches from the Level 2 protocol stemming from the Salem-Keiser/Cascade Model by John Van Dreal and additional threat assessment concepts from the Level 2 training by the Manny Tau, Psy.D. (threat assessment skills). A test-phase for a Level 2 Community referral and consultation process from Level 1 Threat Assessment Teams was instituted and data collected.

For FY 22-23, Dr. Holifield revised the MOU to reflect the new Piloted Level 2 Process as well as expectations for community partner attendance at B-HARP trainings. At Community Partner Meetings and Level 2 Threat Advisory Meeting (Level 2 Threat Consultation Meetings) from May 2022 to September of 2022, community partners were presented with piloted procedures of the Level 2 process related to confidentiality, presentation of cases, how student cases would be shared, etc. The key component was to beta-test a multi-disciplinary Level 2 Community Threat Assessment Team and threat assessment protocol. MOUs were sent and many were returned and signed with only one district wanting a small language change. None of the community partners had major questions or concerns about the Level 2 Process.

Cultural Competency

The cultural competence goals were incorporated into the project design and included in the project administration, delivery, and evaluation. Equal access to services without disparities was achieved by providing all participants with equal opportunity to participate in the project and by providing the training tests in the primary language of the participant. The community advisory group monitored the project for disparities in services using process data and community data provided by the project data analyst.

Research Questions

1. What are the best approaches for the teaching and training of threat assessment procedures for MHPs, LE and EL staff in a community with limited resources?

2. What are the best components that make an efficient, coordinated, and collaborative system and model related to threat assessment for MHP, LE and EL staff?

3. What are the best methods to increase prevention and early detection and engagement as it relates to threat assessment?

4. How should MHP approach and treat individuals who have made threats or gestures towards homicidal violence?

5. How to best educate parents, educators, mental health professionals and the community about threat assessment principles and include them in the referral and monitoring process?

6. How to avoid stigmatization and criminalization of individuals, families, and community members who have participated in the threat assessment process when the threat was not found to be credible?

Project Goals

Goal 1--Provide Stakeholder/Participant Training-
a) *Objective*-Increase the level of skill and knowledge of mental health professionals (MHP), law enforcement (LE), and educational institution (EI) staff to identify and prevent school and community threats as defined and assessed by a training model.
b) *Outcomes*-Metrics include the number of pre/post retrospective surveys, testing objective knowledge via multiple choice questions, and roster of training participants. Training/consulting expert progress reports will be collected.

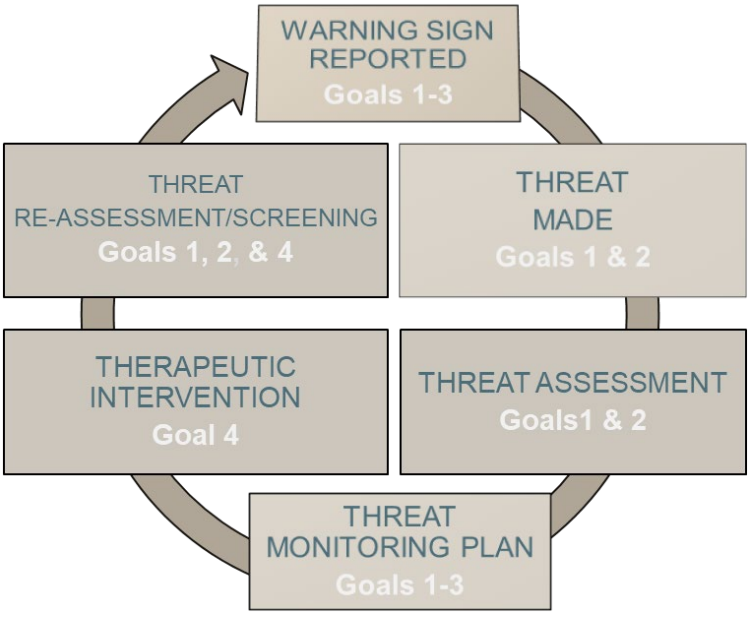
Goal 2-- Develop a Community Threat Assessment System-
a) *Objective*- Increase the level of interagency organization collaboration through the development and use of the coordinated and collaborative training system and model for threat assessment.
b) *Outcomes*- Metrics include documentation of interagency meetings and the number of coordinated collaborative threat assessments conducted by B-HARP Teams. This includes (e.g. source, type, level, recommendations), awareness of

potential stereotypes via reflections and open-ended responses, and interagency B-HARP team knowledge, skill, communication assessment via expert case review, review of collaborative threat reports, and self-report.

Goal 3-- Community Education and Outreach on Warning Signs-
a) *Objective*- Decrease the number and level of potential threats identified through referral and increase the number of threat assessments provided to individuals making threats.
b) *Outcomes*- Metrics include the number of threats and their levels before the participants attend training and after the participants attend training. The number of threat referrals and source of referral (parent, teacher, student, etc.) will be documented. The number of agency and community presentations will also be documented.

Goal 4--Increase Knowledge of Mental Health Intervention Approaches
a) *Objective*- Increase the number of MH professionals available to provide therapy to individuals who make serious threats. Increase the knowledge of MH professionals of threat assessment process. Increase the number of referrals to mental health professionals for individuals who have made threats.
b) *Outcomes*- Metrics include documented training and presentations to MH professionals on threat assessment process, pre/post survey of MH professionals in community who feel comfortable receiving referrals, and number of referrals provided to MH professionals based upon threat assessment recommendations.

Figure 1: Project goals embedded in the B-HARP Mission Model:



IMPLEMENTATION

Design

The B-HARP project instituted a training protocol that included clinical and community-based training topics delivered in a set six (6) to nine (9) full-day training sessions offered during the testing phase. Training sessions would be directed towards mental heal professionals (MHP), law enforcement (LE), and educational institution staff (EI). B-HARP would also provide educational engagement practices to minimize criminalization and stigmatization of youth in cases of threats. Additionally, the project aimed to ensure the referral, assessment, and monitoring of threats were properly coordinated between entities as part of the learning and testing phase.

Clinical trainings included intensive one/two (1/2) day sessions for each of the following:

1. Baseline Training providing content and didactic learning, experiential activities, role plays, and case conceptualizations.
2. Supplemental Training for selected community experts focused on assessment tools and implementation.
3. Follow-Up Training to measure and assess knowledge and skill retention.
4. Expansion Training led by the clinical or community expert and/or the selected community experts who will proctor and impart knowledge and skill-based practices.

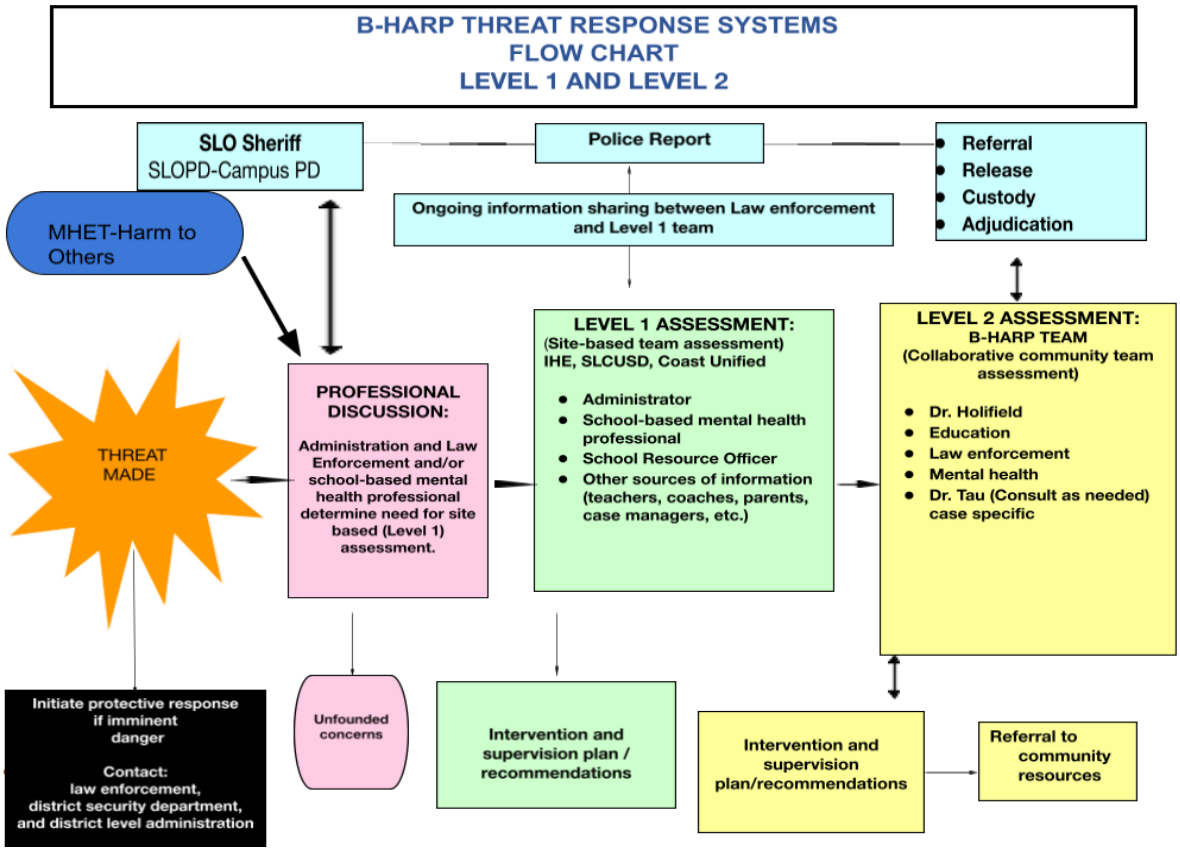
Community-based trainings included two (2) intensive two (2) day sessions for each of the following:

1. Community System Training providing content related to interagency communication and collaboration techniques, agency policies and procedures, legal issues, and community monitoring.
2. Community Supplemental Training focused on designing, developing, and on-boarding community-based threat assessment cases.
3. Legal Consultation Training focused on the legal issues surrounding threat assessment and compliance with regulations.
4. Community Presentation Training focused on experts providing educational and learning opportunities to parents, primary caregivers, MHP's, EI staff and administration, and interested community members.

Training Model

The B-HARP training curriculum is based on the Salem-Keizer/Cascade Preventative Behavioral Threat Assessment and Management (BTAM) model. This concept is a community approach to threat assessment that emphasizes communication across all school personnel when deciding how to respond (Van Dreal, 2016). Salem-Keizer also considers the fewer resources available to non-urban schools when it comes to preventing violence (Van Dreal, 2016). The B-HARP adaptation is shown in the figure below:

Figure 2: B-HARP Threat Assessment Response Model



Level 1 Team

In this model, each school would develop a Level 1 team made up of administrators, resource officers, and mental health professionals (Goal 3). Following the expression of a threat, if the situation does not suggest imminent danger, the involved students are separated by a responsible adult and a report is made to a member of the Level 1 team, who then determines whether the threat warrants an assessment.

Assessments require gathering information from as many relevant parties as possible including teachers, the students involved, witnesses, parents, and anyone else the assessor deems pertinent. Following the gathering of information, the Level 1 team member responds to a series of questions within the threat assessment questionnaire (Appendix 1) to determine both the severity of the threat as well as the most preferable response. Before a final decision is made, the questionnaire is shared with the rest of the Level 1 team to diversify the perspectives assessing the situation (Goal 2).

The advantage of Level 1 team members is found in their proximity to everyone involved. Because the team is made up of individuals the students may know, the Level 1 team is likely more capable of getting accurate information than law enforcement. Its members also have a better understanding of a given student's situation and the context under which the threat occurred. The intention of the Level 1 team is for situations to be handled by the school personnel that understand the severity of certain situations and when they may require additional support (Goal 2). In such instances, the thoroughly documented threat assessment is passed up to the Level 2 team, made up of local law enforcement and mental healthcare providers.

Level 2 Team

By design of the Salem-Keizer Cascade System, the Level 2 Community Team is comprised of professionals from school districts, other education institutions, law enforcement, public mental health agencies, juvenile justice/probation, and the district attorney's office. Following a concerning threat that may be complex for a local school site or district to manage, this multidisciplinary and multiagency group assesses the situations of concern for violence and supports schools with solutions, resource exploration, and supervision planning. For any community, a possible extension of this group can comprise of an Investigative Team made up of a few members trained in more advanced threat assessment and management skills and uses a Level 2 protocol to provide an assessment that will provide a deeper understanding of the student and situation.

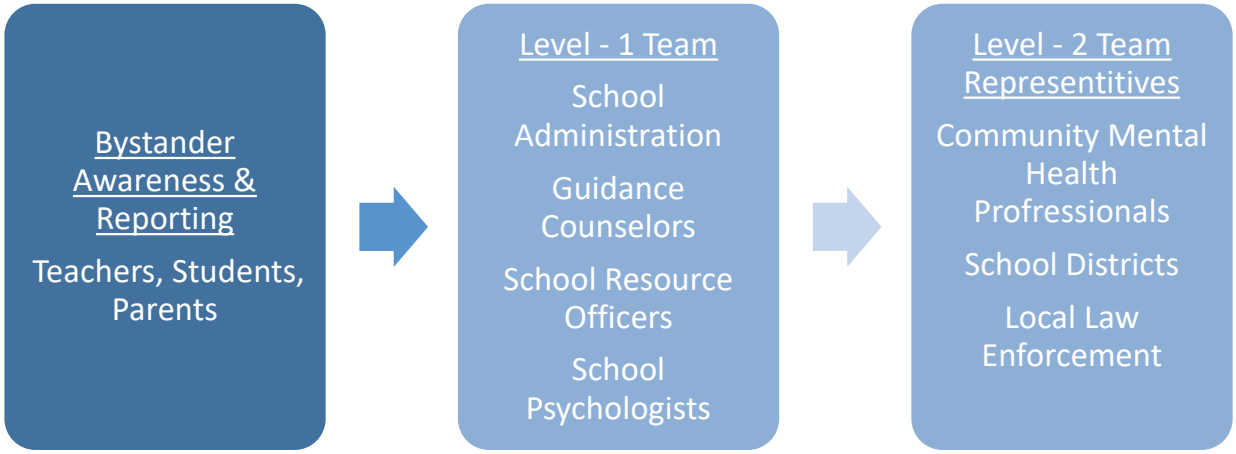
The Level 2 team is a smaller group that serves all the schools in the county. Whereas the strength of Level 1 is found in their greater knowledge of the student at the school site-level, the benefit of Level 2 is their deeper understanding school violence in relation to more advanced threat assessment training and knowledge of community resources to support the student. While this team is used when a threat

appears to be more concerning and potentially urgent, their role, as much as possible, is to avoid criminalization of youth and provide an opportunity to divert a youth away from legal action and into community supports and treatment.

Training and Educational Initiatives

The training provided by B-HARP to participants largely correspond with their levels, as shown by the figure below, with arrows indicating the direction a reported threat follows:

Figure 3: B-HARP Training Levels and Participants



Most of B-HARP's training serves to build-up and maintain Level 1 and Level 2 teams. Given that the Level 2 Team is limited to 1-2 representatives per district and agency, the composition of the Level 2 team reached a point of completeness with most community partners represented, with an average of eight members of the total team of 20 meeting regularly to discuss threats. A one-day refresher training is conducted once a year for all members (Goal 1). As for Level 1, the constant flux of new school employees and the greater number of teams makes frequent training necessary, with about three to four, twelve-hour community trainings organized a year (Goal 3).

Since its inception, B-HARP has conducted numerous on-site and virtual training events and established a framework by which channels of communication have been opened. Regardless of their results, it is undeniable that the organization has built a considerable network of education, law enforcement, and mental health professionals. The consequences of changing approaches or simply discontinuing support should be considered in addition to program efficacy when determining

whether funding should be continued.

Methodology

Empirical Strategy

To understand the level of success of the B-HARP Innovation, the project evaluators relied on data collected from the training programs. The analysis is broken down into two groups: (1) teacher training and (2) Level 1 team training. A mixed-method approach of pre- and post- training survey data was leveraged for the analysis, and participant observations during the training examined training engagement and changes to threat assessment proficiency. Paired t-tests were utilized to observe changes in respondents' knowledge and attitudes pre- and post-training.

Quantitative Approach

Teachers

Quantitative outcome on teachers is determined based on a comparative analysis of pre- and post-training assessments collected at three separate teacher training events. Prior to their one-hour training, teachers are emailed a link to two assessments. The first of these measures is teacher's attitude, asking respondents to rank their feelings when it comes to school violence and their ability to report a threat on a four-point Likert scale (1-strongly disagree, 2-disagree, 3-agree, 4-strongly agree). The second is a true/false quiz about the research behind threat assessment, school violence, and the warning signs to test teacher knowledge. Upon the end of training, participants are asked to complete the same assessments once more for the sake of comparison, along with an additional 4-point Likert scale survey evaluating the quality of the training.

Conclusions were formed by examining the change in the average scores before and after training of several factors including average correct answer and average teacher comfort in threat assessment. In addition, the analysis examines which questions, in particular, yielded the most positive and negative responses. Paired (testing change in each individual) and unpaired (looking at the change in the group as a whole) t-tests were also run on all questions in the attitudinal survey, as well as the average number of correct answers in the knowledge test. This was done to determine the average change in answer across individuals as well as across the entire group. Also, not every teacher answered both the pre- and post-training assessment.

Level 1 Teams

Quantitative outcomes on Level 1 teams are based on a comparative analysis of 2023 pre- and post-training surveys and tests of Level 1 participants. The focus on 2023 is due to the year's trainings being relatively unaffected by the COVID-19 pandemic and accordingly, its large amount of high-quality data. The content of these assessments is similar to those provided to teachers, with identical knowledge questions and slight changes to several attitudinal prompts for relevance. The most significant difference between the assessment of these teachers and Level 1 teams can be found in the Likert scales used for participant attitude; specifically, those receiving Level 1 training are asked to report their feelings when it comes to their competency of threat assessment on a six-point Likert scale (1-strongly disagree, 2-disagree, 3-somewhat disagree, 4- Somewhat agree, 5-agree, 6-strongly agree), as opposed to a four-point scale that was used for teachers.

Like with teachers, conclusions are drawn by running paired and unpaired t-tests on knowledge before and after the training to determine the average change in correct answers across individual participants and the entirety of the reported data, respectively. However, program success for this group was weighed largely by the results of the attitudinal assessment, the questions for which can be found in Appendix 4, as these participants are the ones conducting actual threat assessments. While knowledge is important, assessments are conducted through a step-by-step process by a team of people, making memorization of concepts not as critical. Conclusions for this element are measured by additional paired and unpaired t-tests run on questions related to administrator confidence in their ability to understand and perform threat assessment procedures.

Qualitative Approach

In February 2023, a participant observation study of an in-person Level 1 training was performed. On day one of the training, B-HARP's instructor focused mostly on instruction and lecturing, leading report observations to concentrate on seating arrangement, participant engagement, and the frequency of audience questions asked. Day two of the training was devoted to group case study and threat assessment practice. Observations were made based on sitting in on a variety of groups and taking note of communication style and differing approaches to the question.

Changes to Project

A year into the project, the COVID-19 pandemic forced schools to close, requiring B-HARP to significantly alter their approach. Trainings had to be conducted online, a

setting which made collaboration between attendees difficult. There was also a question of how relevant a discussion on school violence was when there was no indicator of when or how schools would operate upon reopening. This context is important to take into consideration when evaluating B-HARP's results, not only in providing leniency to any related setbacks, but also in giving recognition in instances of savvy adjustment.

Limitations

The sample size was a limitation to project accuracy. Many training participants did not fill out all assessments, either before or after the training, making it difficult to track individual progress. Additionally, because of complications due to the COVID-19 pandemic, the overall number of planned trainings and training attendance had to be reduced, leading to fewer data points.

OUTCOMES & OUTPUTS

ANALYSIS

Teachers

Teacher outcomes are evaluated based on pre- and post-training assessments about teacher comfort, attitude, and knowledge of threat assessment. As shown in Figure 4, B-HARP's training did little to impact teacher concern for school shootings. Rated on a four-point Likert scale (1-strongly disagree, 2-disagree, 3-agree, 4-strongly agree), teacher worry about school shootings (Questions #1 and #2) largely remained steady between the pre- and post-training attitude test. There was a slight positive change to the comfort teachers felt about reporting threats (Questions #4, #5, and #6), though these indicators averaged high positive scores already during the pre-test. However, questions related to teacher comprehension and ability to report a threat (Questions #3, #7, and #8) saw a statistically and substantively significant improvement, with all three averages being pushed into the affirmative (above 3). Outcomes of the t-tests from all three questions saw a decrease in the standard deviation across individual and overall responses, indicating an increase in consensus toward the affirmative. Full results of the t-tests can be found in Table 1. Importantly, a key prompt -- "I understand my role in my school's threat assessment process (Question #8)" -- increased the greatest, with the average growing nearly 25% from 2.8 to 3.3. Also, the prompt "I understand my school's process once a concerning behavior has been reported (Question #7) showed a substantive increase in the post-test.

Figure 5 shows further encouraging results within the threat assessment knowledge quiz (see Appendix 3 for assessment questions). Prior to the training, the average final score was 59%. Due to the assessment being comprised solely of true or false questions this outcome was only slightly higher than if participants had answered questions randomly. However, correct answer averages improved across the board following the post-test, with the average final quiz score jumping 30 percentage points to 89% (see Table 1). According to the t-test, the increase across average total knowledge scores is statistically significant.

Figure 4: Average Score to Pre- and Post-Training Attitude Prompts, Teachers

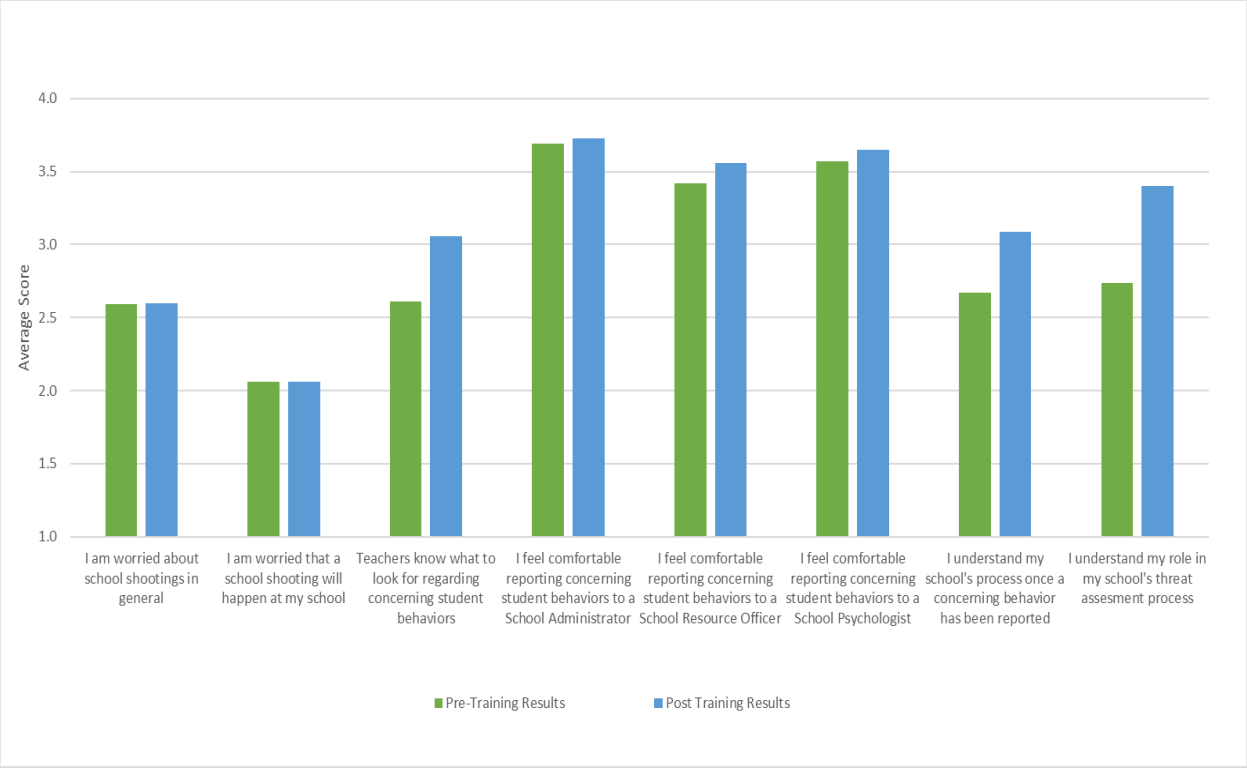


Figure 5: Pre- and Post-Training Correct Answers, Teachers

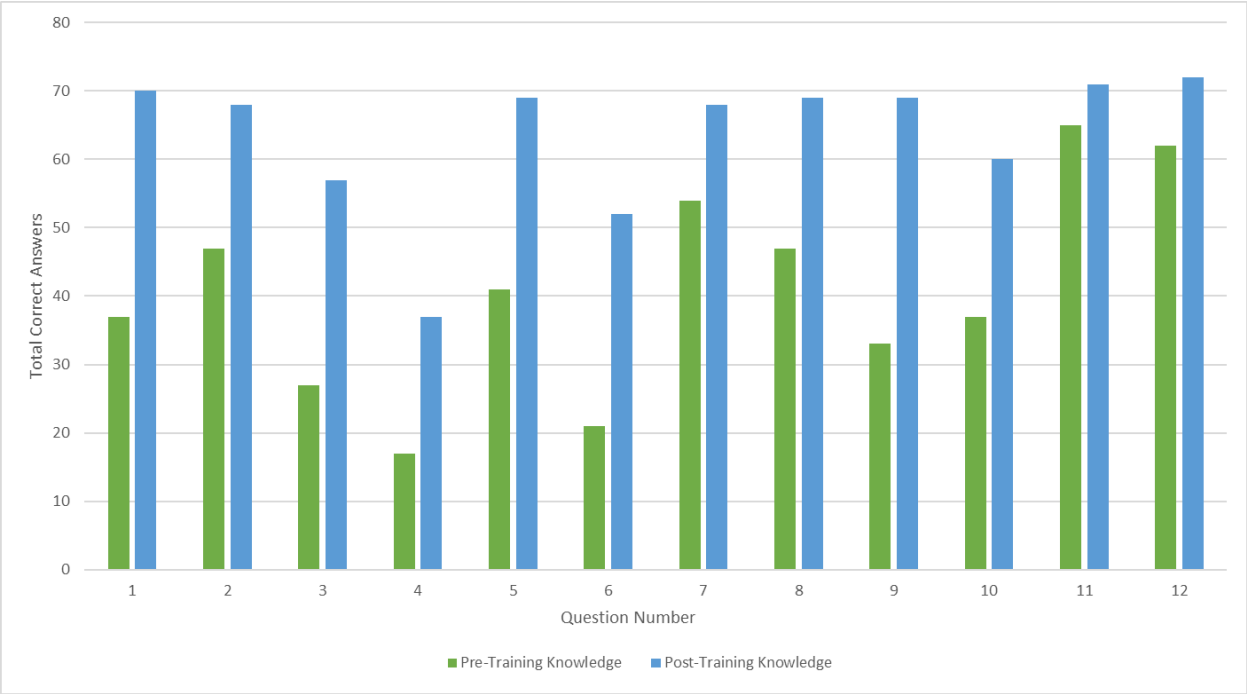


Table 1: Teacher T-Test Results for Attitudes & Knowledge

	Pre-Training	Post-Training	Difference	Sample Size
I am worried about school shootings in general.	2.51 (.131)	2.551 (.137)	.041 (.109)	49
I am worried that a school shooting will happen at my school.	2 (.105)	2.071 (.099)	.071 (.074)	49
Teachers know what to look for regarding concerning student behaviors.	2.653 (.119)	3.031 (.101)	.378 (.136)*	49
I feel comfortable reporting concerning student behaviors to a School Administrator.	3.694 (.089)	3.735 (.064)	.041 (.087)	49
I feel comfortable reporting concerning student behaviors to a School Resource Officer.	3.468 (.129)	3.596 (.108)	.128 (.108)	47
I feel comfortable reporting concerning student behaviors to a School Psychologist.	3.633 (.1)	3.714 (.077)	.082 (.087)	49
I understand my school's process once a concerning behavior has been reported.	2.693 (.137)	3.163 (.107)	.469 (.151)*	49
I understand my role in my school's threat assessment process.	2.796 (.134)	3.429 (.123)	.633 (.123)*	49
Knowledge	7.123 (.388)	10.692 (.14)	3.569 (.382)*	65

* indicates statistical significance at the $p<.05$ level.

Level 1 Team

Change in knowledge was largely consistent with the positive results found in teacher assessments (see Table 2 and Figure 6). The average number of correct answers in individual knowledge tests increased by nearly three points (from about 67% correct to about 83% correct). However, as stated previously, greater weight was given to the attitudinal survey, measuring the change in participant attitudes confidence in their ability to run threat assessments. The t-tests run on questions #3 ("I feel confident in my knowledge of threat assessment principles"), #4 ("I feel confident in organizing and coordinating a threat assessment team to perform a threat assessment"), and #5 ("I feel confident in my ability to develop and manage a safety plan following a threat assessment") all saw statistically significant improvements, both among average individual and overall surveys. More specifically, all questions began with a slight sub-4 (agree) average to their prompts, indicating a minor lack of confidence in participant ability - these responses averaged in the affirmative by the end of training. All results can be found in greater detail in Table 2. As Figure 7 shows, not all questions saw an increase pre- and post-test, however, uncertainty exists as to why a training would increase (or decrease) questions which are about concerns over school shootings ("I am worried about school shootings in general" and "I am worried that a school shooting will happen at my school"), as discussed earlier with teachers.

Figure 6: Pre- Post-Training Correct Answers, Level 1

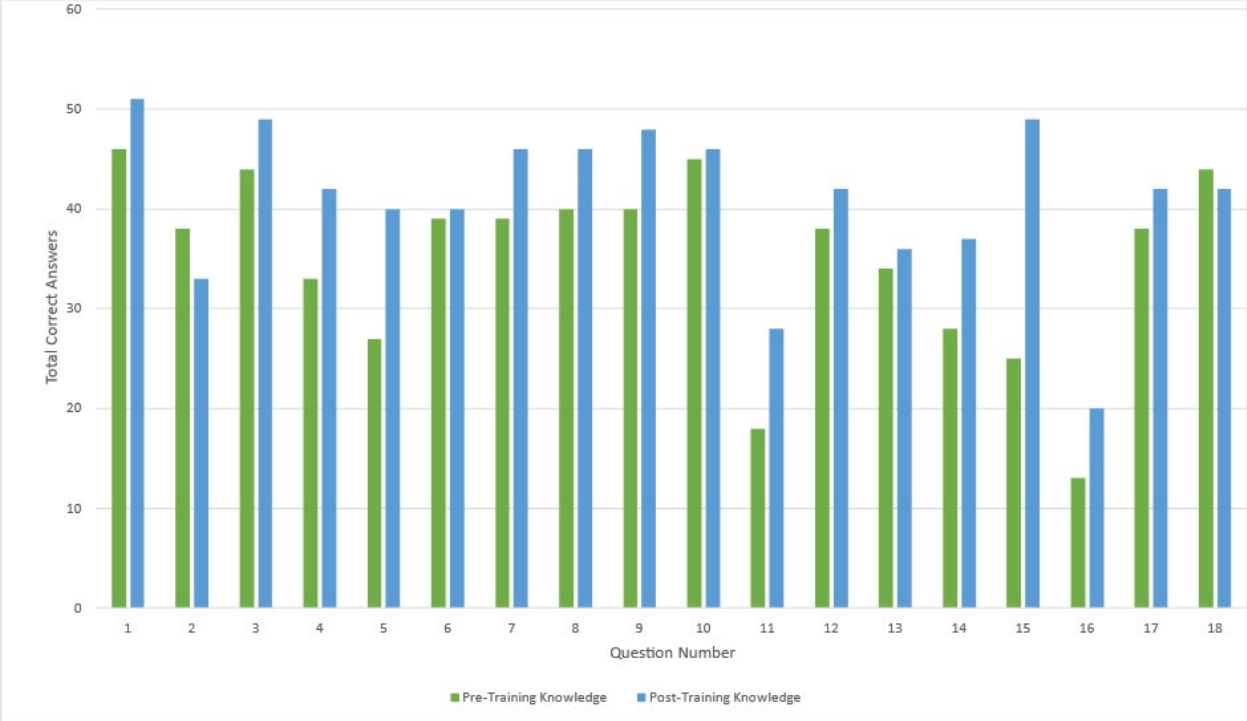


Figure 7: Average Score to Pre- and Post-Training Attitude Prompts, Level 1

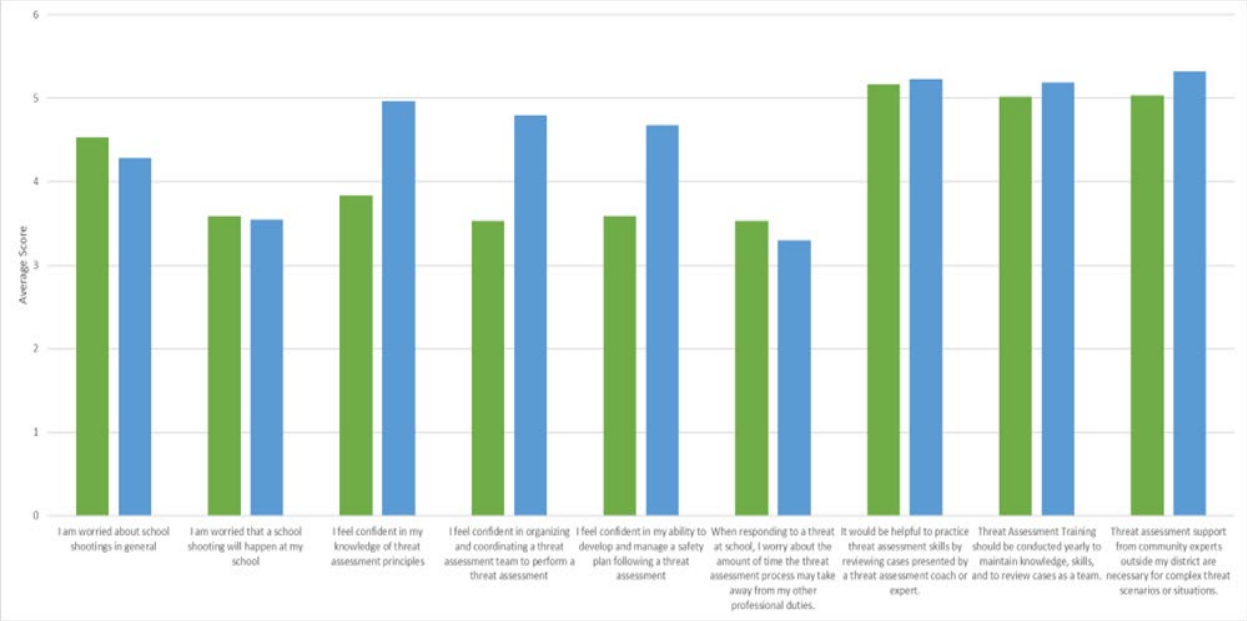


Table 2: Level 1 Team T-Test Results Attitudes & Knowledge

	Pre-Training	Post-Training	Difference	Sample Size
I feel confident in my knowledge of threat assessment principles.	3.897 (.155)	4.923 (.068)	1.026 (.14)*	39
I feel confident in organizing and coordinating a threat assessment team to perform a threat assessment.	3.564 (.201)	4.692 (.091)	1.128 (.169)*	39
I feel confident in my ability to develop and manage a safety plan following a threat assessment.	3.641 (.166)	4.564 (.115)	.923 (.185)*	39
Knowledge	12.028 (.395)	14.912 (.294)	2.889 (.318)*	36

* indicates statistical significance at the p<.05 level.

Qualitative Outcomes

Level 1 training was also observed by a member of the evaluation team to qualitatively assess efficacy. Upon entering on day one of training, participants were free to select whichever seat they preferred. Seating was arranged in groups of two folding tables pushed together with about eight seats per table. As participants entered, most sat with people they already knew, resulting in folks from the same school and job description clustering together. The school resource officers (SROs) gathered more closely than the rest of participants, choosing to pull over chairs to occupy a single table past initial capacity.

The first day was devoted mainly to background information, relevant research on school violence, and a detailed walkthrough of how to conduct a threat assessment. Training began with a series of vignettes, the details of which required audience participation to make them more relevant to the participants' personal experience. As the training went into more technical detail, these vignettes were referenced back to as examples for how the information communicated was applicable. As the day went on, it was clear that the audience was invested in the outcomes of the characters within these narratives, sometimes reacting audibly to themselves and nodding their heads in recognition as B-HARP's speaker introduced new elements. Based on the evaluator's observation, this storytelling approach kept participants engaged in the training while also offering a memorable anchor to which they could connect the training content.

Day two of training gave the Level 1 Team the opportunity to put what they learned to the test in a series of group case studies. For the most part, participants returned to the same seats they chose on the first day, allowing differences in approach between employment backgrounds to become apparent. The table of SRO's took a highly collaborative approach, with one senior member reading the prompt aloud to the rest of the team and all tablemates working through the problem piece by piece. This group was also by far the most spirited, using the entirety of their work time for discussion.

Administration, on the other hand, took a more individualistic approach. Members of these groups would read the prompt silently and come to a conclusion before choosing to speak with their team. These groups often struggled to fill the entirety of their allotted time with discussion, often ending with moments of silence before the speaker asked for thoughts from the entire audience.

The arrangement of the seats did not lend itself to ease of discussion. The size of the tables made it difficult to hear someone speaking at the other end, leading groups to clump together into smaller subgroups around the corners of the tables to discuss prompts. One team made up of older administrators moved their seats away from the table into a circle in the corner of the room. This team was comparatively more involved than other groups, though it is hard to tell if this was due to their seating arrangement or for their already developed relationship with one another.

Future trainings might think critically about how the classroom structure shapes engagement. Moreover, assigning seats versus letting participants choose seats may

have consequences for the outcomes of training. Based on our observation, the freedom to choose seats appeared to decrease opportunities for collaboration across SROs and administrators. However, the benefit was that participants might have been more willing to participate authentically among those they already know.

LEVEL 1 RESULT SUMMARY

The B-HARP trainings were highly successful based on empirical analysis. Regarding project outcomes and goals, the evaluators observed statistically and substantively significant increases in knowledge (Goal 1 "Increase and maintain threat assessment knowledge", Goal 3 "Educate school/campus staff, students, and parents about behaviors of concerns") and attitude (Goal 2 "Community design of threat assessment of best practice model. Increase community collaboration and utilization of threat assessment skills" and Goal 3).

Teachers

The scores taken from teacher training tests showcase B-HARP's fulfillment of their stated Goals 1 and 3 ("Increase and maintain threat assessment knowledge", "Educate school/campus staff, students, and parents about behaviors of concerns"). The results show that teachers both demonstrate and self-report an improved understanding of threat assessment. However, it should be noted that they remain somewhat apprehensive of their ability to act when/if the need for them to report a threat should arise.

Level 1 Recommendation

Level 1 teams demonstrated the knowledge and confidence necessary to perform potentially lifesaving threat assessment. However, these teams also need more encouragement if they are to truly optimize the strategy. B-HARP's approach to Level 1 training appears to be adequately engaging but requires some adjustment when it comes to the training layout to get the most out of case study exercises. During the training, the evaluators observed a missed opportunity to improve upon Goal 2 ("Increase community collaboration and utilization of threat assessment skills") as individuals appeared to self-select according to profession and familiarity. The trainings offer an opportunity to build collaboration. Moreover, leveraging diverse expertise of participants in the trainings may lead to a higher value training experience.

MENTAL HEALTH PROVIDERS TRAINING

In October 2021 three-hour training was a collaboration between Dr. Holifield and Dr. Manny Tau (Clinical Expert). It was specifically designed for mental health providers in San Luis Obispo County, especially those who might not have been to a B-HARP training Level 1. That training previously had only been offered to mental health providers working with school district threat assessment teams. The Mental Health Provider training was designed to meet Goal 4 and educate mental health professionals on warning signs, psychological risk factors, BTAM principles, and professional reporting obligations should clients make threats. It was designed to be a community link presentation to educate therapists in the community about the basic process school threat assessment teams were conducting and to work with those teams if having a shared student and client. Participants were offered three hours of Continuing Education credit for attendance and 35 of the 50 participants fully completed both the Mental Health Provider Pre-Test and Post-Test.

Mental Health Professionals were asked where their primary mental health professional activities were conducted.

- 31% responded School or University-based institutions.
- 20% responded Community Mental Health Agency-County.
- 34% responded Community Mental Health Agency-Non-Profit.
- 8% responded to Private Mental Health Practice.
- 6% responded Other.

The participants focused on all age groups in their practices with the majority reported working primarily with clients ages 13-24. In a key question that highlighted the need for the training, ***82% of participants reported that they have worked with individuals who have made targeted threats towards others.***

Knowledge Section:

Below are takeaways from the Mental Health Professionals Knowledge Test. For the Mental Health Provider Knowledge Test there was a Maximum Test Score=10.

Percent Knowledge Increase for Aggregate and Matched Pairs for Mental Heal

MHP	MHP Pre	N	MHP Post	N	Percent Increase
Aggregate (Groups)	67.96	35	85.00	22	**25.08**
Matched	69	20	85	20	**23.19**

In examining the data above, there was an increase by Mental Health Provider participants in their understanding of warning signs, psychological risk factors, BTAM principles, and professional reporting obligations should clients make threats.

Opinion Section:
In the Mental Health Providers Opinion Section, items were designed in a 5-Point Likert Scale format (Strongly Agree---Undecided----Strongly Disagree) focusing on issues with clients and threatening behavior related to referrals, case management, disclosure of PHI, etc. Key shifts from Pre-Training to Post-training were noted on the following items from (Disagree, Undecided, Agree to **Strongly Agree)** with ***Pre-Post***

Strongly Agree
Percentages listed below:

- **I *believe that a community-based threat assessment and management system is necessary to prevent acts of targeted violence.***
  - Pre-Test=48.72% and Post-Test= 66.67%

- ***Community and school-based mental health professionals have an important role in both threat assessment and threat management.***
  - Pre-Test=57.89% and Post-Test=90.48%

- ***I believe knowledge of threat assessment would be useful in my therapeutic work with clients who are aggressive and potentially violent.***
  - Pre-Test=55.26% and Post-Test=72.7%

- ***I believe the use of disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public, provisions in HIPAA permit the disclosure, in good faith***.
  - Pre-Test=39.47% and **Post-Test=75%**

The changes in the professional opinions are complementary to the increase on the Knowledge Test scores of threat assessment principles. The opinion data lends itself useful to posit how the professionals in this training may apply their knowledge in a clinical setting. The most critical opinion items changed was the last listed above. Disclosure of PHI may be necessary at times and in California, licensed mental health professionals have an obligation to report threats that their clients may make towards others. This data reiterates the importance of BTAM training that is customized for the typical mental health professional who practices in the

community as opposed to training designed to train mental health professionals to be forensic specialists.

Training Evaluation and Feedback

In conversations held with the participants and through analysis of the feedback section of the evaluation forms, the overwhelming consensus was that the training was effective the participants yearly retention of the training would be useful. Dr. Holifield and Dr. Tau had attempted to fit a significant amount of content into the three -hour period, which drew appreciation from the participants, but proved difficult in the limited time span.

Successes and Key Highlight:

A lasting impact from the Mental Health Providers Training is the 15 participants that stated they would be interested in joining a community network of licensed professionals dedicated to threat assessment identification, triage, and treatment. Thus 30% of the participants following this training indicated a desire to be a part of a Mental Health Provider network in the community designed to support school threat assessment teams, as well as students of concern who have been assessed by Level 1 Teams, with potential mental health services. This finding of the project is deemed to be a crucial component of an effective threat assessment network and B-HARP highly recommends this strategy to any communities employing similar methods.

LEVEL 2 RESULTS & PILOT CASES

Level 2 Training & Outcomes

For the first two years of the grant, measure of advanced threat assessment knowledge was evaluated using the BTAT-A. In late October, 2020 and in 2021, the Level- 2 took place with a select group of individuals who had progressed through the General Training, many who had attended the Level 1 Refresher Training. The overall configuration of the Advanced Training was identical to the General Training with regards to virtual environment, and registration and assessment processes. Below are the results of the Level 2 Team:

Percent Increase for Level 2 Team Supplemental Trainings:

Training	Pre-Percent Correct	Post-Percent Correct	**% Increase**
2020 Level 2	75.00	86.73	**15.65**
2021 Level 2	60.00	90.48	**50.79**

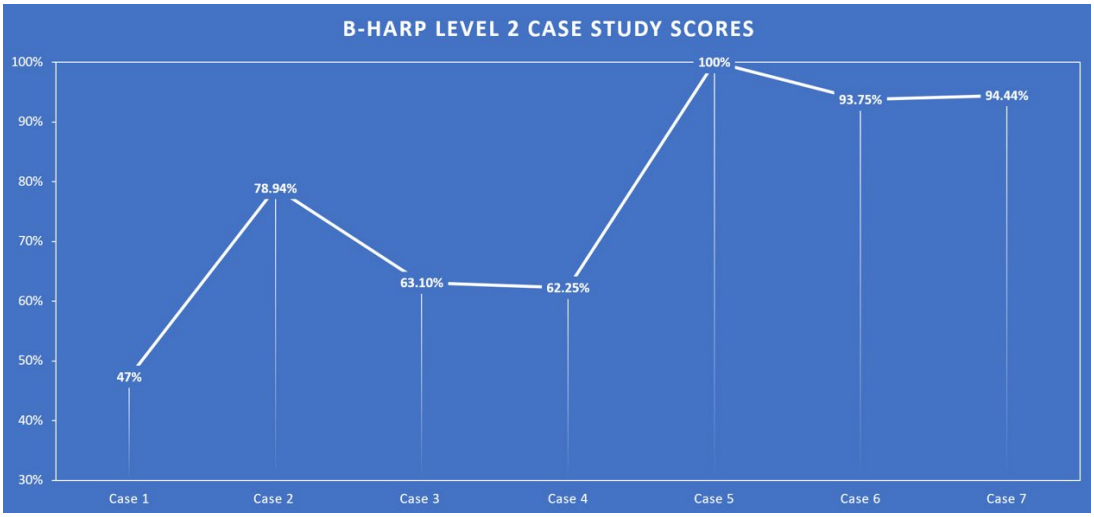
Case Reviews-Clinical Applications-Level 2

The original goal for the B-HARP project was to have the community experts begin conducting threat assessment post training. In the 2018-2019 proposal it was conceptualized that the B-HARP Team would present actual cases to the Clinical Expert. The expert would provide expert feedback and suggestions to the team. However, due to COVID-19 restrictions and schools having online learning, the focus of the educational partners was health related concerns, not school violence. None of the partners reported incidents of school threats during this period.

To address this issue, Dr. Holifield created a Level 2 B-HARP Team Training Syllabus. The purpose of this training series was to maintain training fidelity, create a team atmosphere in case review, and practice analyzing complex threat assessment cases. A training syllabus was crafted to reflect specialized topics such as interviewing and debriefing as well as 7 cases to be presented by the clinical expert. A B-HARP Level 2 Case Organizer was created for Level 2 Team members to organize the case information as they read it into specific threat assessment and management areas to be evaluated by the Clinical Expert.

After each Level 2 Case Team Review, brief feedback was provided by the expert. The Clinical Expert would score the team on each section of the Case Organizer, so that the team could pinpoint areas of improvement.

Figure: Level 2 Team Assessment Accuracy By Practice Case



The Level 2 B-HARP Team was found to have increased their threat assessment abilities in the 6-month span of the training, averaging a 66% overall score on the Clinical Expert's rubric from the first four Case Studies and 95% in the latter three

Case Studies. This increase was observed despite of the Clinical Expert increasing the difficulty of the cases each time. Dr. Tau did not provide this information to the Project Director and Level 2 Team until after the last case. Thus Level 2 Team participants were unaware (blind) to the increase in difficulty and complexity, yet made gains in accuracy overtime.

Interagency Collaboration

The original proposal noted that there would be thirty percent (30%) increase of interagency collaboration through the development and use of the coordinated and collaborative training system and model for threat assessment. Measurement and metrics to analyze this approach was originally conceptualized as the number of Level 2 Cases completed by Level 2 Team Members. However, when the COVID-19 Pandemic emerged and continued throughout most of the grant process impacting onboarding of the Level 2 process, different metrics were established. The focus became on measuring attendance at the established meetings in the grant that, by design, required interagency collaboration and the development of the Level 2 Community Process.

Attendance would be total and duplicated among Level 2 community stakeholders (Educational Institutions, Law Enforcement, and Mental Health). Prior to FY 2021-22, attendance was measured in grant logs, tabulated meeting attendance in-person, email confirmation, and Zoom attendance matched with Zoom attendance sheets.

Table 3: Percent Increase of Interagency Level 2 Team Collaboration

Interagency Activity	FY 2019-20	FY 2020-21	FY 2021-22	FY * 2022-23	Percent Increase
Level 2 Team Threat Consultation Attendance (Threat Advisory)	0	42	85	91	116.67%

***** *Attendance data were tabulated only to March 1, 2023 (end of the grant activities).*

The Level 2 Meetings did not begin until January of 2021. Since there were no cases due to COVID-19, further training in threat assessment concepts and case reviews were extended for 6 months. It was not until January of 2022 that some schools and agencies were sending direct referrals to the B-HARP Level 2 Threat Assessment Team. Some of these were bypassing a Level 1 assessment as word spread to the community about a potential "community threat assessment team." Although

mentioned in the Level 1 and Level 2 Trainings, the process had to be refined to discuss concerns from Level 1 School Teams reiterating the understanding that the schools had to use the Level 1 Protocol prior to a referral to a Level 1 Consultation. Attendance increased during this time and reflected input from multiple partners on further refining a process for meetings. By the end of the grant, with a more formalized process in place, attendance had increased even though data only reflected 75% of the academic year as grant tabulation ended March 1, 2023.

System Outcomes

In June 2022, B-HARP distributed a survey to the Level 2 Threat Consultation Team Members that was designed to capture data regarding threat assessment cases and reports that had been conducted in the county. Data was collected from designated Level 2 members representing the districts. For districts that attended the training but had not yet adopted the Level 1 Protocol and attended Community Partner Meetings, the survey was provided as well.

Table 4 demonstrates a community process that is invested in upstream prevention of school violence by filtering out concerns and situations that may not be a threat. By having a community consultation team, districts were able to receive support for students who may be at greater risk for concerning behaviors.

TABLE 4: Level 1 School District Threat Assessment Reporting and B-HARP Community Process

School District Threat Assessment Process Reporting*	FY 21-22	FY 22-23
School Districts that Received Level 1 Training	6	7**
School Districts Using Level 1 Piloted Protocol and Level 2 Process	5	5
Total Threat Assessments Completed-All B-HARP Trained Districts	29*	114***
B-HARP Professional Discussions	19	80
B-HARP Level 1-Protocol Threat Assessments Conducted	29*	42
B-HARP Level 2-Threat Consultation Team Meeting Consultations	5	14

*Note: School Districts only reported total number of threat assessments, and did not provide information about other areas in their survey.
**Two school districts had teams attend Level 1 Training but not adopted Level 1 Protocol for use.
***For comparisons, this data was for the entire school year Aug-22- June 23 by which the evaluation period ended in March of 2023.

Pilot Cases

Case 1 - Student-Warning Signs in a Therapy Session

One evening, Dr. Holifield received a call from one of the Level 2 Team Members who supervises mental health therapists at a local mental health agency (Level 2 Mental Health Team Member). According to the Level 2 Team Member, the therapist reported to her that her client, an adolescent, discussed in a therapy session that she was concerned about her friend becoming a school shooter. It is noteworthy that the therapist had previously attended Dr. Holifield and Dr. Tau' Mental Health Providers in October of 2021 which was part of Goal 4. The therapist remembered some key components of concerning behaviors and warning signs from the workshop and referenced the workshop handouts. She asked her client further questions about the client's boyfriend's behavior and became concerned. Specifically, her client's friend talked about school shootings in general and the Oxford High School Shooting in Michigan. The therapist reported the client's concern was that her friend was showing an increasing frustration with peers and teachers at school that was mixed into the couple's discussions.

The Level 2 Mental Health Youth Team Member and Dr. Holifield triaged the case, located the school district of the client's friend, and contacted the school resource officer for that high school, who was also a Level 2 Law Enforcement Team Member. The resource officer then contacted the high school administrator that evening to schedule a Level 1 school threat assessment for the following morning. The conclusion from the threat assessment was that there were emotional and behavioral concerns, but no planning or research to attack the school. Law enforcement visited the student's home, interviewed the parents about weapons access which there were none. This student was referred for mental health therapy.

This case example demonstrates the effectiveness of a community team approach by being able to contact the key team members, share important information, triage a case, and develop a measured response. This also highlights the effectiveness of Goal 4 and the main purpose of this grant, to educate mental health professionals on behavioral warning signs associated with Increasing Knowledge of Intervention Approaches Among Providers and Provider Capacity.

Case 2: Level 2 Community Team Assist and Advice

A threat assessment conducted after a student bystander informed a teacher about a student who had recruited another student to" kidnap and kill a girl" whom the student did not like because that student was "too happy." The student had been asking a few other students to assist her. The MHET and local police went to the

student's home. Rope and tape were found at home that were to be used. A district trained threat assessment team in collaboration with law enforcement completed a threat assessment. There were significant concerning factors related to the student's trauma history, sense of abandonment, and several preparatory actions associated with a loose plan for kidnapping the student. The MHET Team concluded concerns related to harm to others and the student was hospitalized. Upon return the student then received outpatient mental health therapy with a local agency. Level 2 Threat Assessment Consultation Team Members were consulted by the school district about a school safety plan as well as with the mental health agency treatment team regarding intervention approaches.

CONCLUSIONS & NEXT STEPS

Over the course of three years, and despite a global pandemic, B-HARP has created an original threat assessment framework and assembled an interconnecting team of community figures to address violence in schools. Its training has informed participants with a variety of age groups, educational backgrounds, and career paths. Lines of interdisciplinary communication have been opened across San Luis Obispo County and the concept of threat assessment has been taught to hundreds of professionals and community members.

The final year of the B-HARP Innovation grant increased use of the Level 1 Protocol by school districts. The planning and goals focused on further piloting the implementation of the Level 2 Team Consultation Meeting Process. At Community Partner Meetings and Level 2 Threat Advisory Meetings (School Threat Consultation Meetings), procedures were created, discussed, and edited and a revised MOU was sent to school districts. The goal was to measure the process of the Level-2 Threat Advisory Team Meetings in terms of student cases referred or brought before the team. This process oversaw the discussion and documentation of the interagency collaboration and cooperation on twelve cases brought to the meetings. A *Level 2 Student Threat Incident Consultation Pilot Protocol* was crafted with input from both clinical experts and the community. It was intended for use by a small group of designated professionals on the Level 2 Team to use a supplementary consultation using interview forms and criteria to provide a more in-depth review of the concerns from the Level 1 Team. This protocol was Beta Tested for one highly, complex case that had shared components from all three Silos (educational institutions, law enforcement, and mental health).

The launch of the beta test for a Level 2 Team process has led to a continued partnership between San Luis Obispo County and Holifield Psychological Services past the MHSA Innovation grant. After connecting with various community members through the SLO Chamber of Commerce, the foundation of a possible community threat assessment network was laid. This network includes local business owners, school district staff, local mental health facilities, law enforcement, and the SLO District Attorney. This collaboration resulted in a partnership between Holifield Psychological and the SLO DA's office to continue to support B-HARP activity via a 3-year grant referred to as the Bureau of Justice Administration STOP School Violence Grant. The STOP grant will continue the work B-HARP started with the MHSA Innovation grant for a further 3 years of funding.

Additional materials for the B-HARP project can be found in Appendix 1 and include:

- List of references to the project in presentations, workshops, invited addresses, and testimony.
- Level 2 Case Review Clinical Expert Score Sheet.
- Copy of Confidentiality Agreement for Level 2 Team.
- Transcript of witness testimony presented by Dr. Holifield at a Senate Education Committee Hearing in support of AB 99; a threat assessment and violence prevention legislation.
- Letter of Support from California Polytechnic University in San Luis Obispo.

The Holistic Adolescent Health (HAH) Project

PROJECT OVERVIEW

The HAH project was designed to test the co-creation of a new health curriculum and delivery model for youth ages 13-18. With the addition of mindfulness training, the project implements a comprehensive approach to mental, physical, and social health. Adding a mindfulness skill-building component to the existing high school health curriculum sought to enhance the ability of adolescents to make positive life choices related to their own health and well-being. At the time of the proposal, there were no studies found that presented a supportive model that integrates mindfulness into an existing health curriculum covering physical, sexual, and social health for teens ages 13-18 in a school-based environment. The project was instituted at both Morro Bay High School in the San Luis Coastal Unified School District and Lopez Continuation High School in the Lucia Mar Unified School District.

The HAH project developed and instituted the following components:

- Blended health education model that provides 15 sessions of mental health, physical health, and sexual health education to students through their regular health classes.
- Offered a Health Educator that provided one-on-one health coaching for individual mental, physical, and sexual health education support for interested students.

The in-class component expanded the current curriculum to include mental health, physical health, and sexual health education units. The mental health units included Mindfulness Awareness Practices (MAPs) such as the STOP process (Stop, Take a Breath, Observe, and Proceed), body awareness scans, breathing, meditation, and feelings identification. The physical health units included the U.S.D.A.'s MyPlate nutrition education, training on how to read nutrition labels, meal planning, setting SMART (Specific, Measurable, Attainable, Realistic, Time-bound) goals, setting fitness and nutrition goals, and fitness coaching. Sexual health units focused on healthy relationships, pregnancy and STI prevention, and birth control methods.

Health coaching involved students meeting one-on-one with a Health Educator up to two times per month for approximately 30 minutes per session throughout the school year. The discussions were student-driven and focused on setting and meeting health goals, developing mindfulness skills, and additional education on specific topics of personal interest for each participant.

BACKGROUND

The issue HAH examined was San Luis Obispo County's lack of a coordinated school-based health curriculum that provided high school students with a comprehensive mental, physical, and social health education. Community Action Partnership of San Luis Obispo (CAPSLO), in collaboration with local schools, determined that the current compartmentalized curricula limited the ability of county youth to attain a whole-person/holistic view of heath or to balance the inter-related aspects of mental, physical, and social health engagement processes. With students reporting ever-greater struggles to cope with overwhelming stress and anxiety, school officials and staff were asking for resources on how to help teens manage in the currently overcharged social environment. This need became a priority as it addressed two areas of concern, one being actively engaging youth ages 13-18 and, secondly, incorporating a comprehensive approach for mental, physical, and social health with mindfulness.

Locally, it had been identified that 7.5% of Central Coast youth have experienced a serious emotional disturbance (California Health Care Foundation, 2018, p. 6). According to the Community Health Improvement Plan, of the 11th grade students in San Luis Obispo County surveyed in 2015-2016, 33% reported experiencing chronic sadness or hopeless feelings in the past 12 months (2018). According to the California Healthy Kids Survey, 33% of 9th Grade students in the Lucia Mar Unified School District (LMUSD) and 31% of those in the San Luis Coastal Unified School District (SLCUSD) had experienced chronic sadness or hopelessness. The numbers for non-traditional students rose to 44% and 53%, respectively. Nineteen percent of students in Grade 9 in the LMUSD and 15% of those in SLCUSD had considered suicide, and those rates again increased to 22% and 38%, respectively, for those in a non-traditional school setting (CalSCHLS, 2018).

In discussing the state of school-based health services, the 2018 California Children's Report Card reports that although some efforts are being made to "improve school climate and teacher training to support student wellness, and increased screening and referral for mental health and trauma services, more must be done to develop a [coordinated system of care] that meets kids' needs." San Luis Obispo County designated the improvement of the social and emotional support network for teens in SLO County as one of two Social and Emotional Wellness Priorities (Community Health Improvement, 2018). The County believes teaching mental health coping skills to teens is a vital determinant of the overall health of youth and an important component of early intervention efforts.

In October 2018, a new round of Innovation projects was launched beginning with an initial Innovation Community Advisory Committee meeting. The meeting consisted of reviewing MHSA Innovation guidelines and developing the process for proposing and selecting a project or projects for the next 4 years of funding. Community members included mental health providers, educators, community members with lived experience and family members, as well as County partners and local CBO's. The County made available information containing steps to successfully submit an innovation idea, along with providing technical assistance in developing the narrative piece of the proposal.

One of the most enthusiastic and eager organizations was CAPSLO's Teen Wellness division. At an initial meeting they presented the first iteration of their idea to integrate and develop a new mental health curriculum that included mindfulness, physical, health, and social-emotional development. This project is part of a larger collaboration between CAPSLO and local high schools, focusing on the development of a new curriculum and delivery model. Unanimous support was given by the Innovation Committee and the County and State approval process began.

The project continued to be refined as County staff, CAPSLO, and school representatives became involved in the proposal. The original project design is the result of community engagement between CAPSLO, local school districts, and youth. Additionally, the SLO Behavioral Health Department has provided technical assistance to refine and coordinate efforts to make the proposal a priority in reference to what the community needs are. The project design utilized feedback from schools identifying the need for additional support and a comprehensive curriculum that addresses the needs in teen developmental areas, including the need to build a curriculum and delivery model that leads to youth being connected to mental health services and a recovery process when needed. The continued collaboration between community advisors, community members, and school staff affirmed the community-wide acknowledgment of the dire need for a cohesive and comprehensive curriculum so that county youth are provided with an opportunity to feel engaged and achieve success and mental health wellbeing. Final approval for the project was accomplished in the fall of 2019, and CAPSLO was awarded the contract via the SLO County Purchasing process.

Cultural Competency

The project was designed to impact diverse youth from across the County. The project employed culturally and linguistically appropriate staff who engaged students through service delivery that fosters equal access to services without

disparities. Additionally, through the community development process, the project incorporated culturally and linguistically appropriate guidance in the development, administration, implementation, delivery, and evaluation stages of the project.

IMPLEMENTATION

The ramp-up stage for HAH began in October 2019. CAPSLO's Teen Wellness partnered with Morro Bay High School and Lopez Continuation High School to implement the program in-classrooms as part of their health education classes offered each semester. The key components of the project included:

- Blended health education model that provides 15 sessions of mental health, physical health, and sexual health education to students through their regular health classes.
- Health Educator one-on-one health coaching program that provides individual mental, physical, and sexual health education support for interested students.

The in-class component built on and expanded the schools' current curriculum. The HAH project incorporated mental health, physical health, and sexual health education units. The mental health units included Mindfulness Awareness Practices (MAPs) such as the STOP process (Stop, Take a Breath, Observe, and Proceed), body awareness scans, breathing, meditation, and feelings identification. The physical health units included the U.S.D.A.'s MyPlate nutrition education, training on how to read nutrition labels, meal planning, setting SMART (Specific, Measurable, Attainable, Realistic, Time-bound) goals, setting fitness and nutrition goals, and fitness coaching (2018). Sexual health units focused on healthy relationships, pregnancy and STI prevention, and birth control methods.

The health coaching component involved students meeting one-on-one with a Health Educator up to two times per month for approximately 30 minutes per session throughout the school year. The discussions were student-driven and focused on setting and meeting health goals, further developing mindfulness skills, and additional education on specific topics of personal interest to the student. Each session also included mindfulness training.

The curriculum was conducted by the Health Educators. The Health Educators received approximately 200 hours of extensive training covering topics related to all aspects of the blended health education model. After completing the training sessions, Health Educators participated in an evaluation process before presenting

to students in the classroom and engaging students through one-on-one health coaching. This process included observing trainers, presenting mock teaching sessions, and co-teaching. Through the training and evaluation periods, Health Educators received ongoing support and feedback from supervisors, trainers, and peers. Additionally, two of the Health Educators were certified by the National Board for Health and Wellness Coaches during the project, thus elevating their capacity to better engage students during the one-on-one coaching component.

The proposed timeline of the HAH project involved 6 cohorts over the course of 3 full school years beginning in January 2020. Each cohort consisted of delivering the in-class modules to approximately 60 students ages 13-18 across both school sights, health coaching to volunteers from the in-class modules, and pre- and post-assessments for every participating student. CAPSLO then reported data at the end of each cohort to the Cal Poly Innovation Evaluation (CIE) team.

CHANGES TO PROJECT: IMPACT OF COVID-19

The initial rollout of the HAH operations quickly became challenging due to the suspension of in-person classes in early 2020. The project component most impacted was the ability to gain interest for one-on-one coaching sessions where students could have more specialized and focused support of their developmental health needs. The initial projection of serving 40 students annually was based on the number of students typically served in person through other programming at CAPSLO Teen Wellness. As a result of the pandemic, the goal shifted to serving 10 students in 1-1 coaching per year.

The initial agreement with the school partners was to provide the coaching support services in person at the school sites during school hours, thus allowing students with easy access to the service. Due to the COVID-19 pandemic, HAH was not able to provide in person curriculum implementation, nor coaching, so there was a pivot to providing options for 1-1 virtual coaching, and curriculum instruction via ZOOM. Due to the elevated social, emotional, and mental impact students faced because of the pandemic, the numbers of participants that were initially anticipated for one-on-one drastically decreased. The project then elevated their marketing efforts and incentive strategies to students for 1-1 virtual coaching. Although Zoom, google meet, and telephone calls were offered, students engaged mostly with coaching via 1-1 texting. When school campuses returned fully to in person learning, a year after the start of the project, youth still felt most comfortable accessing 1-1 coaching sessions via text. As addressed in the data analysis section of this report, this structure of 1-1 coaching produced promising results.

Due to the inability to engage with students in-person as planned until the 2nd year of the project, CAPSLO was able to use saved funding from the delayed start to extend their testing into an additional semester in 2023. During this time, they opted to assess the delivery method of the curriculum by substituting the Health Educators with current school staff. This concept was not included in the original proposal, but in collaboration with the County, it was identified to be a productive tangent that could provide insight into the scale-ability of the in-class curriculum. The evaluation of this exercise has been added to the CIE analysis in this report.

RESEARCH QUESTIONS

PURPOSE AND METHODOLOGY

The learning goals of the HAH project included:

1. The impact of the model on effectively increasing the ability of teens ages 13-18 to cope with stress and anxiety.
2. How does incorporating the teaching of mindfulness practices in conjunction with other health-focused curriculums increase teens' ability to make healthy decisions regarding their mental, physical, and sexual well-being.
3. Does the inclusion of one-on-one coaching increase the likelihood that students will practice what they learned in health classes.
4. What are effective methods to increase prevention and early detection of mental health-related issues.

The data collection methods utilized to examine these learning goals included pre- and post-surveys of participating students in both the in-classroom experience and one-one-one coaching. Supplementing the quantitative data, motivational interviews were conducted with students to assess the intentionality regarding behavioral changes related to gaining knowledge from participating in one or both project's components.

EVALUATION OVERVIEW

The goal of the CAPSLO HAH project was to increase the quality of mental health services, including measured outcomes, by implanting a new health education model in two SLO county schools: Lopez High School and Morro Bay High School. Three features of HAH made the program unique: (1) the co-creation of curriculum with youth ages 13-18, (2) the inclusion of mindfulness training into health education, and (3) one-on-one coaching and follow up with students who seek additional mental, physical, and sexual health education and/or support.

Leveraging pre- and post-classroom course surveys and surveys students completed after participating in one-on-one coaching, the CIE team assessed the extent to which the CAPSLO HAH program accomplished its stated goals. Although many challenges in the data were identified, the overall improvements in desired outcomes were observed including statistically significant improvements in student knowledge after completing the classroom course.

OUTCOMES & OUTPUTS

To assess the extent to which HAH accomplished their stated goals, the CAPSLO team surveyed students before and after the classroom health course and after one-on-one coaching. De-identified, un-matched data were shared with the CIE team. The survey tool(s) asked students questions about demographics, knowledge (via true/false questions), health relevant behaviors, nutrition, feelings, skills at coping with stress or making decisions, frequency of use of mindfulness behavior, and other topics identified to be of interest to students.

Table 1 below summarizes student demographic data for the 381 students who took the classroom pre-test survey. Of the 381 students, 295 attended Morro Bay High School and 86 attended Lopez High School.

Table 1: Summary statistics of student sample

	No Disability	Identifies Disability	Prefers not to answer/ NA
Disability Status	282	75	23

	8th	9th	10th	11th	12th
Grade	.54%	49.3%	6.2%	19.0%	24.9%

	English	Spanish	Other	Prefer not to answer
Primary Language	.54%	11.1%	4.5%	5%

	Male	Female	Unsure	Trans	Gender Queer	Another/ Prefer not to answer
Gender Identity	57.9%	32.6%	2.4%	1%	1%	2.6%

	Heterosexual/ straight	Gay/ Lesbian	Bisexual/ Pansexual/ Fluid	Questioning	Queer, other	Prefer not to answer
Sexual Orientation	72.2%	1.6%	15.7%	2.7%	3.18%	4.8%

	American Indian/ Alaskan Native	Asian	African American/ Black	Native Hawiian/ Pacific Islander	White/ Caucasian	Other	More than one race	Prefer not to Answer
Race	9.4%	5.2%	2.4%	1.6%	38.6%	26.8%	17.1%	5.8%

Goal 1: Does the model effectively increase the ability of teens ages 13-18 to cope with stress and anxiety?

To assess the relationship between HAH program and the ability of teens to cope with stress and anxiety, CIE compared survey question answers from the beginning of the course to the end of the course about worrying, coping with stress, and feeling tired, unhappy, hopeless, and nervous. Table 2 lists the survey questions and scale, the pre-test mean, and the post-test mean score.

Importantly, the de-identified data could not be matched to individual students, so CIE compare overall averages before and after, which is a less nuanced comparison than identifying changes within individual students. The aggregate answers to the questions listed in Table 2 show minor change. Of the eight questions, scores increased in a desirable direction for five measures, although the changes are not statistically significant. The conclusions CIE draw from these changes are limited, though, due to the nature of the data and the use of overall averages for two reasons: First, more students completed the pre-test than the post-test, so the comparisons between pre- and post-class answers compare different groups of students. If, for example, students with high levels of mental health coping skills decided to drop the course and did not complete the post-test, the aggregate comparison would underestimate changes in coping skills for the students who remained in the course. Likewise, without being able to match surveys to students, these group averages blur together heterogenous effects. For example, perhaps a few students faced crises during the course and their scores on their capacity to cope questions dropped substantially. If so, the modal student might have a substantial increase in coping skills, but that increase is offset by some students who may have had a large decline in self-reported experiences.

Table 2: Mental Health evaluation

Variable/Question	Pre-Test Mean (number of responses)	Post-Test Mean (number of responses)
People sometimes feel sleepy during the daytime. During your daytime activities, how much of a problem do you have with sleepiness? 0-4 Scale (0=A very big problem 4=Not a problem at all)	2.67 (333)	2.65 (246)
During the last two weeks, how often were you bothered or troubled	1.08	1.11

by feeling too tired to do things? 0-2 Scale (0=Much; 1= Somewhat; 2=Never)	(331)	(245)
During the last two weeks, how often were you bothered or troubled by having trouble going to sleep or staying asleep? 0-2 Scale (0=Much; 1= Somewhat; 2=Never)	1.15 (330)	1.21 (246)
During the last two weeks, how often were you bothered or troubled by feeling unhappy, sad, or depressed? 0-2 Scale (0=Much; 1= Somewhat; 2=Never)	1.22 (330)	1.31 (245)
During the last two weeks, how often were you bothered or troubled by feeling hopeless about the future? 0-2 Scale (0=Much; 1= Somewhat; 2=Never)	1.34 (330)	1.36 (245)
During the last two weeks, how often were you bothered or troubled by the following? Feeling nervous or tense 0-2 Scale (0=Much; 1= Somewhat; 2=Never)	1.06 (330)	1.05 (244)
During the last two weeks, how often were you bothered or troubled by the following? Worrying too much about things 0-2 Scale (0=Much; 1= Somewhat; 2=Never)	0.94 (332)	0.95 (245)
On a scale from 1-4, rate your ability to cope with stress. (1=Not able to cope at all, 4=Very able to cope	2.98 (330)	2.97 (242)

Goal 2: Will the incorporation of mindfulness practices in conjunction with other health-focused curricula increase teens' ability to make healthy decisions regarding their mental, physical, and sexual well-being?

To assess Goal 2 regarding the relationship between the incorporation of mindfulness practices into other health-related curricula on teens' ability to make healthy decisions regarding their mental, physical, and sexual well-being, CIE compared pre- and post-class survey responses to for two sets of questions. First, CIE compared students' knowledge about health-related questions before and after the course. While increased knowledge need not necessarily lead to improved decisions, knowledge seems a plausible component of healthy decision making. Table 3 reports the class average number of correct answers for 23 true/false questions before and after the course. At the start of the course, students answered approximately 18.7 out of 23 answers correctly. After the course, that score increased to approximately 19.5, a difference that is statistically significant. In other words, completing the course is associated with higher scores on a knowledge test for students.

Table 3: Difference in Knowledge

Correct score out of 23 True/False Questions	Pre-Test Classroom	Post-Test Classroom
Mean	18.69	19.45
Variance	5.53	5.43
Number of Observations	310	251
T-Stat	3.82	
P-Value	.0001	

Second, students are asked about their confidence in making decisions about different subjects. Table 4 shows average levels of confidence about making decisions before and after the classroom health course. There are modest improvements for Sexual and Mental health, and the difference in means test for confidence in making decisions about mental health is statistically significant (p=.044).

Importantly, it is difficult to infer what changes in these scores might mean. Ideally, the HAH project aimed for teens to be more confident about their decisions, which would stem from knowledge and access to information or resources. It is possible that some students may have false confidence, or confidence that stems from misunderstanding or lack of information. If some student confidence is, indeed, "false" confidence—particularly at the start of the health course— as students learn more about health and consequences, a modest decrease in confidence in decision-making might reflect more accurate self-awareness.

Table 4: Before and after average scores on Decision-Making Confidence

How Confident are you that you can Make Decisions (1=Not Confident at All; 4=Very Confident):	Mean (Pre-Test Classroom)	Mean (Post-Test Coaching)
About your Overall Well-Being	3.04	3.06
About Healthy Food Choices	2.86	2.87
About your Physical Health	3.01	3.00
About your Sexual Health	3.23	3.31
About your Mental Health	2.78	2.93

Goal 3: Will the inclusion of one-on-one coaching increase the likelihood that students will practice what they learned in health classes?

Thirty-one students submitted post-coaching surveys, nine from Lopez High School and 22 from Morro Bay High School. Of those 31 students, 26 provided answers to the substantive survey questions. The students who utilized the one-on-one coaching answered the same questions about knowledge and behaviour as in the classroom pre- and post-tests. Ideally, CIE would match the coaching students to their pre- and post-classroom surveys to map how answers and behaviour changed from the start of the class, end of the class, and end of coaching. This matching of surveys would allow us to assess the trajectory of growth and identify growth during the class and during the coaching experience. However, as the data were de-identified (in line with data sharing guidelines), CIE cannot match students across surveys and instead rely on averages.

Table 5 compares the averages for all students in the pre-classroom survey and the averages for the coaching students in the post-coaching survey for several questions about utilization of tools/skills. The students' answers at the end of the coaching sessions were significantly higher than those in the classroom pre-test survey for all except one question included in Table 5.

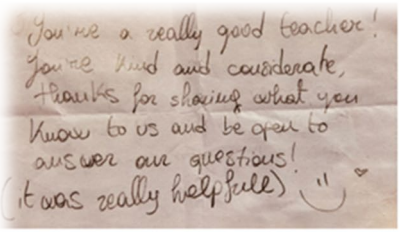
Unfortunately, the data is insufficient to be able to identify how much the difference in scores is related to knowledge and skills gained either in the classroom or through coaching, or whether students who pursue coaching are systematically different from those students who do not and thus have "better" scores for other reasons. For example, almost all coaching students (96%) answered yes (true) to having a conversation with a parent about sex, reproduction, or birth control, whereas fewer than half (39%) of those in the pre-classroom survey answered yes (true) to the same question. It seems likely that the experience of health coaching led students to have conversations with their parents. However, CIE cannot rule out—based on the given data—the possibility that students who are more open with their parents are more likely to be comfortable with and to pursue health coaching. Likewise, students who received coaching may have practiced mindfulness skills more often than other students did overall before taking the health class. It seems likely that the experience of the course and coaching led the students to practice these mindfulness skills more often, but these pre-existing variables cannot be ruled out. Similarly, the post-classroom responses to the same question showed improvement (61%), albeit with lesser impact than the post-coaching results (96%). In comparing all post-test responses for the classroom component and the post-test responses for one-on-one

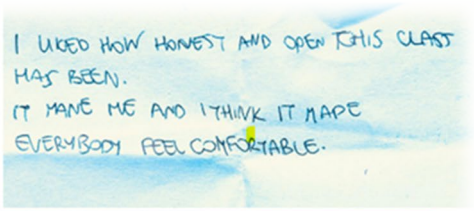
coaching, the results for each question in the survey suggest more desirable outcomes for students that participated in both. Again, the inability to match coaching students to their pre- and post-classroom tests creates an inference issue in this regard that would require more nuance from the available data. Due to these limitations, CIE cannot report statistical significance.

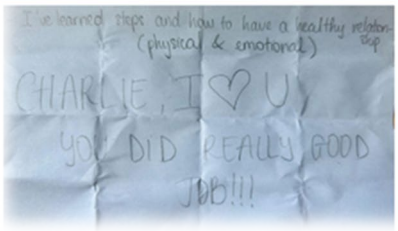
Table 5: Skill utilization between classroom pre/post-test and coaching post-test

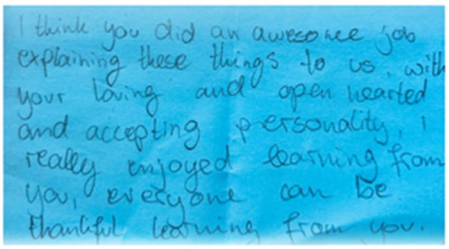
Variable/Question	Mean (Pre-Test Classroom)	Mean (post-Test Classroom)	Mean (Post-Test Coaching)
Conversation with Parent re sex, reproduction, birth control	39% Yes	61% Yes	96% Yes
Knowledge of Reproductive Clinic	28% Yes	68% Yes	92% Yes
Workout Behavior, days per week of exercise	~4 days a week	~4 days a week	~4.5 days a week
Ability to Cope with Stress on 1-4 Scale (4=very able)	2.98	2.88	3.28
Confidence in Making Decisions: well-being on 1-4 Scale (4= Very confident)	3.04	3.06	3.42
Confidence in Making Decisions: Food Choices on 1-4 Scale (4= Very confident)	2.86	2.87	3.2
Confidence in Making Decisions: Physical Health on 1-4 Scale (4= Very confident)	3.01	3.00	3.4
Confidence in Making Decisions: Sexual Health on 1-4 Scale (4= Very confident)	3.23	3.31	3.44
Confidence in Making Decisions: Mental Health on 1-4 Scale (4= Very confident)	2.78	2.93	3.28
Use of 5-4-3-2-1 Mindfulness	2.3 days/week	2.1 days/week	2.4 days/week
Use of Breathing Exercises	2.2 days/week	2.2 days/week	2.9 days/week
Use of Palming	.9 days/week	1.1 days/week	2.2 days/week
Use Mindful Eating	2.3 days/week	2.2 days/week	3.3 days/week
Use of Body Scans	2.2 days/week	1.7 days/week	2.1 days/week
Use of Meditation	1.5 days/week	1.5 days/week	1.8 days/week

The coaching post-test survey asked for student assessment of the experience. Table 6 below shows the proportion of students who answered "strongly agree," "agree," or "disagree" to each of the statements. It is noteworthy that of the 25 students who completed this portion of the survey, none selected "strongly disagree" to any of the statements. Students also had the opportunity to provide written advice for improving the program, examples of the responses are shown below. On the final day of the program, they were able to share something they learned and/or felt they hadn't been able to express in the survey by dropping a written note (example images below) into an anonymous question box.









What advice would you give us on how to improve the program:

- *It's honestly great*

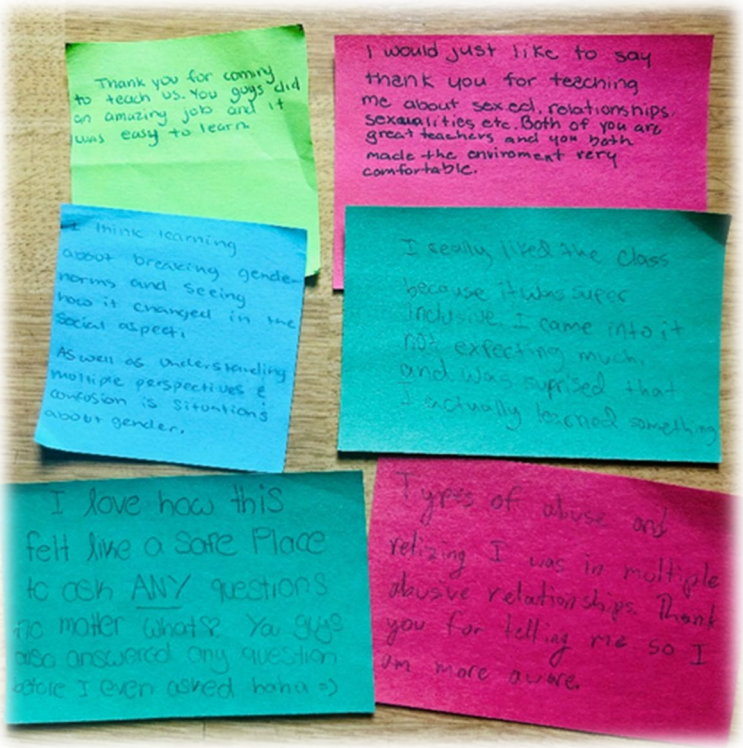


Table 6: Coaching post-test student assessment summary

Question	Strongly Agree	Agree	Disagree
My health coach came to our meetings well prepared.	76%	24%	0%
My health coach was very knowledgeable about the topics.	72%	28%	0%
I enjoyed learning from my health coach.	72%	24%	4%
I learned a lot from healthy coaching.	68%	32%	0%
I would recommend that my friends sign up for a health coach.	68%	28%	4%

Goal 4: What are the best methods to increase prevention and early detection of mental health-related issues?

This is a difficult goal to assess using student survey data. To best assess this goal, CIE would randomly assign students to several different health programs and measure mental health prevention and mental health issue detection across program interventions. Of course, that is not possible here. Instead, CIE used the data reported above to infer whether this intervention—a holistic classroom-based health course and on-on-one health coaching—increased prevention and early detection of mental-health related issues.

To the extent that health knowledge tends to increase prevention and early detection of mental health related issues, the increase in knowledge reported in Table 3 suggests improvements. Likewise, to the extent that a regular mindfulness practice is preventative, the combination of the classroom and coaching component is associated with higher levels of mindfulness practice (see Table 5).

Additional Findings: Student Interest in Curriculum

In addition to assessing the four stated goals of the CAPSLO HAH program, the survey data offer additional insights. For example, the survey asks students what topics they are most interested to learn about in the pre-test and which topics they felt were most important to learn about in the post-test. Table 7 lists the proportion of students who selected each topic in the pre-test and in the post-test. There are at least two interesting patterns to note here. First, the topics that students were most interested to learn about are not necessarily covered in traditional health class

curricula: self-care, healthy relationships, nutrition, and mindfulness. This student interest in HAH specific program topics highlights the importance of a holistic and encompassing approach to health education.

The second interesting pattern to note is how much change there is for some topics between what students were interested in learning at the start of the course and what they that was important to learn at the end of class. Rows in italics in table 7 are those for which there is a 10-percentage point difference between the proportion of students who were interested to learn a topic and the percentage of students who indicated the topic was important to learn. For example, less than 6% of students indicated interest in learning about STIs and testing at the start of the course, but a whopping 30% indicated that this was a topic that was important to learn at the end of class. Of the six topics that saw an increase in student selection between interest in the pre-test and importance in the post-test (in bold), most were about sex and the consequences of sex: in addition to the 24.1 percentage point increase for STIs and testing, Condoms and Protection saw a 10.7 percentage point increase; HIV facts, myths, and stigma saw a 7.8 percentage point increase, and birth control methods a 12.2 percentage point increase. This change between what students were interested in learning and what they thought was important to learn *after* learning it suggests the importance of including sex-related topics in health curricula.

Table 7: Topics students were most interested in.

Which topics are you most interested in learning about? (select 3)	**Percentage of Students who selected each topic as interested to learn (pre-test)**	**Percentage of students who selected each topic as most important (post-test)**
Self-Care	*57.1%*	*32.8%*
Healthy Relationships	47.3%	33.6%
Nutrition	*44.0%*	*22.0%*
Mindfulness	*34.8%*	*22.0%*
Warning Signs of Unhealthy Relationships	24.2%	20.8%
Anatomy	**20.1%**	**10.4%**
Condoms and Protection	***20.1%***	***30.8%***
HIV Facts, Myths, and Stigmas	**15.8%**	**23.6%**
Birth Control Methods	***15.8%***	***28.0%***
Pressure	**11.4%**	**13.2%**
Family Planning and Pregnancy Options	11.0%	9.6%
Identities- SOGIE	8.1%	6.0%
STIs and Testing	***5.9%***	***30.0%***

Additional Findings: Scalability

Due to the project delays and challenges stemming from the COVID-19 pandemic, the HAH project was able to extend into an unplanned cohort that allowed for an assessment of scale-ability in the final year. The earlier courses were led by the CAPSLO programs coordinator, Charley Newel. The final phase of the HAH program in the fall of 2023 at Lopez High School was led by the regular classroom teacher. Table 8a and 8b compared the average knowledge for the pre-test survey for the CAPSLO instructor and classroom teacher (8a) and the post-test knowledge scores for the CAPSLO instructor and classroom teacher (8b). For the combined sessions taught by the CAPSLO instructor, students scored an average of 18.76 questions correctly in the pre-test and 19.49 questions correctly in the post test (an improvement of .73 questions). For the session lead by the classroom teacher, students scored an average of 17.08 questions correctly on the pre-test and 18.29 questions correctly on the post-test (an improvement of 1.2 correct questions). While the students in the teacher-lead class scored statistically significantly worse on the pre-test compared to the students in the CAPSLO-led course, the post-test scores between the CAPSLO-led courses and the teacher-led course are not statistically significantly different, suggesting that the increase in student knowledge is due to the curriculum and not due to the presence of a specific instructor.

Table 8a: Comparisons on Knowledge scores CAPSLO instructor vs teacher, pre-test

Correct score out of 23 True/False Questions	Pre-Test CAPSLO Trainer	Pre-Test Regular Teacher
Mean	18.76	17.08
Variance	5.45	5.08
Number of Observations	297	13
T-Stat	2.55	
P-Value	.01	

Table 8b: Comparisons on Knowledge scores CAPSLO instructor vs teacher, post-test

Correct score out of 23 True/False Questions	Post-Test CAPSLO Trainer	Post-Test Regular Teacher
Mean	19.49	18.29
Variance	5.29	10.57
Number of Observations	244	7
T-Stat	1.35	
P-Value	.18	

Additional Findings: Facilitator Evaluations

The post-test surveys asked students to assess the facilitators. Students overwhelmingly "agreed" or "strongly agreed" to questions about facilitator preparation, facilitator knowledge, enjoyment of learning, and willingness to recommend the program. Some students were less enthusiastic about the amount of information they learned; however, results show average/overall student knowledge did improve.

PROJECT LESSONS LEARNED & RECOMMENDATIONS

While there were statistically significant improvements in knowledge, improvements on other criteria such as confidence in decision-making (Table 4) or mental health-related issues (Table 2) are less clear. Differences before and after the course on questions related to decision-making and mental health-related issues are, at best, modest. However, the interpretation of differences for these questions is less straightforward. Similar to the discussion in the section about the assessment of Goal 2 and the potential role of "false confidence" in decision making at the start of the course, changes in sleepiness, sadness, or nervousness (or other topics covered in Table 2) during the course have less straightforward interpretations. For example, knowledge of what it means to feel nervous, or tense might help students recognize and label feelings that they did not have vocabulary for before. If this is the case, then a student who has consistent levels of worry might report higher levels of worry at the end of the course, not due to poor coping mechanisms but due to new knowledge and emotional self-awareness.

Likewise, there are many explanations for changes in the feelings of students before and after a health course that are unrelated to the course content. For example, some students may become more stressed and tired over time during the school year as coursework and extra-curriculars expend time and energy. If that is the case, then—absent any new knowledge or tactics for coping—there may be increases in the frequency with which students report hopelessness or worry over the course of a semester. If so, then consistency over time (rather than seeing "better" scores over time) might be a positive improvement in student well-being. To test for whether changes in feelings reported in Table 2 stem from the knowledge and skills taught in the HAH program or from changes in student well-being over time would require a comparison to pre and post-test surveys of students who did not participate in the HAH program. To further the research into this curriculum and the impact of one-on-one health coaching, a design involving data collection from a larger population

of students to analyze the results of a sample that participated in the project would produce more robust results. Furthermore, isolating the two mechanisms (in-class curriculum and one-on-one coaching) in an effort to compare the individual impact of each against the greater population of students may produce distinct insight into which methods are most effective in increasing prevention and early detection of mental health-related issues.

CONCLUSIONS & NEXT STEPS

Overall, there is evidence that students' knowledge about mental, physical, and sexual health improved. Interestingly, many students scored well on the pre-test knowledge questions. High levels of *a priori* knowledge make improvements harder to identify, especially when comparing class averages on the pre- and post-test. It is possible that the improvements stem from some students learning a large amount while other students' knowledge stayed the same. Indeed, 42.3% students correctly answered 20 or more questions correctly out of 23 on the pre-test, which left those students little room for improvement. Given the high scores on the pre-test knowledge questions, any improvement in aggregate scores is a success.

Given the complexity of interpretation for many of the survey items and given the limitations for causal inference from un-matched, aggregate pre- and post-test surveys without a control group, the HAH project leaned on the pre- and post-test knowledge scores to demonstrate improvement for the classroom component of the course, and highlighted are the very positive data for those students who participated in one-on-one coaching (Table 5) to conclude that the CAPSLO Holistic Adolescent Health program did have positive effects on the mental, physical, and sexual health of participating students.

Next Steps

The Holistic Adolescent Health Project aimed to provide youth with the opportunities to learn how to take better care of themselves, their bodies, and those around them through high quality sexual health, nutrition, and mindfulness education. Additionally, participants had the opportunity to experience 1-1 health coaching for more customized individual support for their unique health and development needs. In terms of sustainability, CAPSLO has trained their school teacher project partners in the curriculum implementation along with providing technical support beyond the MHSA Innovation funding. Additionally, they are providing curriculum training opportunities to the local school district health science teachers, building their

capacity to provide high quality sexual health education. CAPSLO is also in the process of exploring opportunities where they can continue to prioritize student health by seeking other funding and school partnerships associated with 1-1 health coaching from their uniquely qualified, trained, and national board-certified health and wellness coaches. The San Luis Obispo County Behavioral Health Department will continue to support the initiative through resource sharing, collaborations to further the research, and providing awareness of grant funding opportunities when available.

Appendices

Appendix 1: B-HARP Materials

References to B-HARP and San Luis Obispo Community Threat Assessment Project
Presentations, Workshops, Invited Addresses/Testimony
2021-2023

Van Dreal, J. & Holifield, J. E. (2021, May 12). *A Comprehensive System for Threat Assessment and Management in Schools*. [Pressentation]. Association of Threat Assessment Professionals (ATAP), San Diego Chapter, San Diego, CA (virtual), United States.

Holifield, J. E. (2022, June 29). Assembly Member Jackie Irwin sponsored bill, *AB 99: School Safety: Crisis Intervention and Targeted Violence Prevention Program*. [Invited Witness Testimony]. California State Senate Education Committee Hearing, Sacramento, CA, United States

Holifield, J. E. & Lemm, O. (2022, October 11-14). *Behavioral Threat Assessment and Management: How to Create and Maintain District-Community Partnerships Through Measured Outcomes*. [Workshop]. California Association of School Psychologists, Universal City, CA, United States.

Holifield, J. E. (2023, February 8-10). *Threat Assessment Coaching: Creating Successful Playbooks for Threat Assessment Teams.* [Workshop]. National Association of School Psychologists, Denver, CO, United States.

Holifield, J. E. (2023, March 23). *The Pathway Towards Targeted Violence: The Role of Neurodevelopment in Threat Assessment and Management.* 2023 School Neuropsychology Pre-Conference on Trauma, Aggression, and Targeted Violence (virtual). [Pre-Conference Workshop]. School Neuropsychology Institute, Dallas, TX, United States.

Custer, M., Brock, S. E., Holifield, J. E., Kelly, L. T., Olaya, & Reeves, M, (March 2023). *The Role of Multidisciplinary Threat Assessment Teams in Schools as a Best Practice Approach for Crisis Prevention and Intervention*. [White Paper]. California Association of School Psychologists (CASP). Sacramento, CA

Holifield, J., Hughes, J., Roscup, J., Silmon, K., Scranton, L., Narjaran-Garb, J. (2023, August 8-10). *Grantee Panel: Collaboration-Grantees Share Experiences and Roles of Law Enforcement, First Responders, and Mental Health*. [Panel]. STOP School Violence National Conference-National Center on School Safety (NCSS) and Bureau of Justice Assistance (BJA) U.S. Department of Justice, Richmond, VA, United States.

Holifield, J. E. (2023, October 14). *Community Engagement: San Luis Obispo County's Response to School Violence Prevention.* [Keynote Address]. Community Counseling Center-San Luis Obispo, San Luis Obispo, CA, United States. The LYCEUM: 8th Annual Mentaalth Awards & Education Luncheon | San Luis Obispo Community Counseling Center (cccslo.org)

2021 Level 2 Case Review Clinical Expert Score Sheet

PART 1 – TEAM REVIEW & INPUT
Investigation

Group 1 Case Organizer (4 points)
__ Psychological Risk Factors
__Sociological Risk Factors
__School/Organizational Risk factors
__Stability Factors
__**NO INDICATORS PRESENT IN CASE**
__**GROUP DID NOT ACCURATELY IDENTIFY**

Group 2 Case Organizer (4 points)
Pathway of Targeted Violence:
Grievances-Violent Ideations-Research & Planning, Pre-attack Preparation, Probing & Breaches, Attack
__ Pathway adequately identified
__**NO INDICATORS PRESENT IN CASE**
__**GROUP DID NOT ACCURATELY IDENTIFY**

Predatory Pathway:
__Interest
__Fixation
__Planning
__**NO INDICATORS PRESENT IN CASE**
__ **GROUP DID NOT ACCURATELY IDENTIFY**

Group 3 Case Organizer (4 points)
Aggressor Continuum:
__Affective<---------->Predatory
___**NO INDICATORS PRESENT IN CASE**
___**GROUP DID NOT ACCURATELY IDENTIFY**

Cadence of Aggression:
Intensity, Frequency, Duration
___Cadence adequately identified
___Escalated, plateaued or de-escalated
___Enduring pattern present/Severe & pervasive
__**NO INDICATORS PRESENT IN CASE**
__**GROUP DID NOT ACCURATELY IDENTIFY**

PART 2 – CASE PRESENTATION & DISCUSSIONS AT MEETING
Threat Assessment and Management

Discussion: What is the threat potential level? (1 point)
____*Threat Posturing, Preparatory Behaviors,*
____*Rehearsal Fantasies*
____Level (see below)
Insignificant---Low---Moderate---High---Critical
___**NO INDICATORS PRESENT IN CASE**
___**GROUP DID NOT ACCURATELY IDENTIFY**

Discussion: Are there identified threatscapes? (2 points)
___Any indicators of possible/probable triggers?
___Any significant life events?
___Any indicators of possible 'guardrails' and stabilizing resources?
___**NO INDICATORS PRESENT IN CASE**
___**GROUP DID NOT ACCURATELY IDENTIFY**

Discussion: What are threat management considerations? (3 points)
___Mitigation of threat and/or re-emerging threats
___Containment of all parties involved
___Management of subject & threatscape
___**NO INDICATORS PRESENT IN CASE**
___**GROUP DID NOT ACCURATELY IDENTIFY**

CASE REVIEW SCORE:
Part 1, Group 1:____/4 or **0 if no indicator**
Part 1, Group 2: ____/1 __ /3 **or 0 if no indicators**
Part 1, Group 3:____/1 __/3 **or 0 if no indicators**
Part 2, All Groups: ____/6
TOTAL: ____/18
Comments:
_____
_____
_____

LEVEL 2 CONFIDENTIALITY STATEMENT

B-HARP
PREVENTION, ASSESSMENT, MANAGEMENT

B-HARP STAT does not case manage. The B-HARP STAT (School Threat Assessment Team) is a consultation team that assesses violence and assists case managers with threat management and the identification of resources.

B-HARP STAT
(B-HARP STUDENT THREAT ASSESSMENT TEAM)

B-HARP STAT CONFIDENTIALITY AGREEMENT

The following rules apply while staffing threats and concerns of violence through the B-HARP (School Threat Assessment Team) STAT process:

1. The confidentiality policies of your agency apply.
2. You are responsible for any material (hard copy, documents, reports, etc.) that you present and its dissemination and retrieval after presentation.
3. You are responsible for the confidentiality (see #1) of any documents collected through staffing.
4. If you intend to take any action as part your agency's role, that action must be shared with B-HARP STAT at the staffing.
5. As circumstances change, cases may be restaffed by B-HARP STAT at the request of case managers.

Sign Name	Title/Agency/District	Date

PRINT Name

AB 99

Witness Testimony-Dr. Joseph Holifield

Senate Education Committee Hearing

6-30-22

Thank you Assemblyman Mc Carty

Good morning… Madam Chair and Members of the Committee.

I am Dr. Joseph Holifield, a school psychologist and clinical psychologist for 26 years specializing in children and adolescents. I presently have a practice in San Luis Obispo County.

I am an active member of the California Association of School Psychologists (CASP) and the Association of Threat Assessment Professionals (ATAP).

As a professional with 22 years of experience with school behavioral threat assessment in CA, I am here today in strong support of AB99, Presently, in San Luis Obispo County, I am the grant recipient and Threat Management Coordinator for the Behavioral Health Assessment Response Project (B-HARP), a Proposition 63 funded Mental Health Services Act, INNovation grant.

Our pilot project is a community-based threat assessment approach focused on different (silos or systems) including education, law enforcement, and mental health agencies and integrating these different systems into a singular, unitary threat assessment and safety management model. In other words, One Community-One Model.

The One Community- One Model approach has been demonstrated by the strong interest and participation from key stakeholders including our county superintendent of schools, Sheriff's Office, Director of Behavioral Health, Chief Probation Officer, and our District Attorney. We are starting to examine how we may integrate this project into our county's strategic plan for systems of support, especially for our smaller and rural districts and marginalized communities.

This bill focuses on threat assessment and targeted violence prevention; but, what does threat assessment of targeted violence actually mean?

Behavioral threat assessment is determining whether a student poses threat and has the means to carry-out an attack on a target. Threat assessment IS about diverting that student off a pathway towards an attack and finding support for that student in the school and community. It is a preventive tool, not reactionary.

Grant funding has allowed our community to have a series of threat assessment trainings for school multi-disciplinary teams on how to identify, assess, and manage threats to schools. We have trained over 200 professionals that have included law enforcement, administrators, school psychologists, and school counselors, and community mental health providers.

In practice, we are already implementing provisions of AB99. Our threat assessment approach uses multidisciplinary teams at school sites. The assessment protocol has a built in Equity Lens to guard of potential bias and *promote a school culture of safety, respect, trust, and emotional support of the student in the process.*

I am excited about AB99's language *authorizing LEAs to establish committees to oversee teams* AND *designating a liaison to consult with the Team and providing wraparound services with community partners.*

In San Luis Obispo County, our grant funding has allowed us to create a Threat Advisory Committee, a multi-professional….multi-district….and multi-agency group made up of liaisons who have been trained in advance threat assessment and management skills. We have started discussing school threats in the community and problem solve community solutions.

The tragic events at Oxford High in Michigan and Robb Elementary in Texas, remind us of the potential vulnerabilities that may exist in our schools and communities. It is my belief that school safety and violence prevention is the best when shared collectively with the development of community resources for education, training, and community systems design and implementation. AB99 provides a template to make this a reality.

CA, the Golden State, deserves a Gold Standard in threat assessment and violence prevention legislation in our schools. 18 other states have adopted statewide threat assessment standards. I encourage our state lawmakers to do the same in supporting AB99.

I am happy to answer any questions the committee may have and willing to be a partner in this effort.

Thank you for your time and consideration of my testimony.

CAL POLY
Student Affairs
Dean of Students

Office of the Sr. Associate Vice President for Student Affairs & Dean of Students
California Polytechnic University San Luis Obispo
1 Grand Avenue San Luis Obispo, Ca 93401

March 26, 2019

Re: Letter of Support for SLOTAP

To Whom it May Concern,

As the Sr. Associate VP for Student Affairs, I am writing this letter of support for the SLOTAP grant proposal to develop a threat assessment program in the San Luis Obispo area. At Cal Poly, we are deeply committed to supporting students throughout their Cal Poly experience. Our goal is to ensure that all students have the support and resources they need to overcome challenges and succeed in a safe, welcoming and inclusive environment, so developing a coordinated and collaborative training model to assess and intervene when threats in our community exist is a priority. Cal Poly is motivated to be a collaborative partner in reaching the goals of SLOTAP.

We ensure student success by facilitating referrals, support and advocacy through nonclinical interventions. We also provide follow-up services in collaboration with other university departments or individuals, community agencies, parents or guardians, and stakeholders in the students' success. We assist students who struggle in areas such as psychological health, physical health, relationship issues, family crisis, life trauma, social adjustment, and interpersonal conflict and need a collaborative training model and system to assess and intervene when a threat becomes apparent.

We also strive to facilitate communication between and among parents and the university, support student success by increasing parent awareness of university resources and help parents develop strategies to meet the unique challenges of parenting students through the college years. We partner with SLOPD and CPPD in assessing threats when they arise and believe this training will assist our systems and partnership in improving.

As you can see, Cal Poly is fully committed to the safety and well-being of our campus community and would serve as an effective collaborative partner in the success of SLOTAP.

Sincerely,

Dr. Kathleen McMahon
Senior Associate Vice President for Student Affairs and Dean of Students

Letter of Approval from Mental Health Services Oversight & Accountability Commission (MHSOAC)

MHSOAC
Mental Health Services
Oversight & Accountability Commission

STATE OF CALIFORNIA
GAVIN NEWSOM, Governor

KHATERA TAMPLEN
Chair
LYNNE ASHBECK
Vice Chair
TOBY EWING
Executive Director

November 8, 2019

Anne Robin, LMFT
Behavioral Health Administrator
County of San Luis Obispo Behavioral Health Department
2180 Johnson Ave
San Luis Obispo, CA 03401

Dear Ms. Robin,

Congratulations, the Commission has approved the San Luis Obispo County Threat Assessment Program Innovation Plan (now called the Behavioral Health Assessment and Response Project) on October 30, 2019 up to the amount of **$879,930.40** in Innovation funding over four (4) years.

Thank you for your letter dated November 4, 2019 acknowledging the following changes to the project:

- Individuals with lived experience will continue to be part of the development, implementation, and evaluation of the project and specifically will be included in developing the training program
- The name of the project has been changed to be more consumer friendly and less stigmatizing. The new name is the Behavioral Health Assessment and Response Project.

Please notify Commission staff in writing of the official start date of the Innovation project. Pursuant to the Innovation regulations, the start date is when the County begins implementing the project which is based upon the date funds are first spent or when services are delivered, whichever happens first. (Reference Title 9 CCR, Article 9 §3910.010(a)(1)).

On behalf of the Commission, I would like to thank you for all the work you do in your community.

If you have additional questions or need further assistance, feel free to contact me sharmil.shah@mhsoac.ca.gov or your county liaison Wendy Desormeaux Wendy.Desormeaux@mhsoac.ca.gov.

Sincerely,

Sharmil Shah, Psy.D
Chief-Program Operations

Copy: Nestor Veloz-Passalacqua, M.P.P.-Ethnic Services Manager

Appendix 2: B-HARP MHSA Application

(Project originally titled: SLOTAP)

County Name: San Luis Obispo
Date Submitted: 5.15.19
Project Title: SLOTAP (San Luis Obispo Threat Assessment Program)
Total amount requested: $880,000
Duration of project: 4 years

Purpose of Document: The purpose of this template is to assist County staff in preparing materials that will introduce the purpose, need, design, implementation plan, evaluation plan, and sustainability plan of an Innovation Project proposal to key stakeholders. *This document is a technical assistance tool that is recommended, not required.*

Innovation Project Defined: As stated in California Code of Regulations, Title 9, Section 3200.184, an Innovation project is defined as a project that "The County designs and implements for a defined time period and evaluates to develop new best practices in mental health services and supports". As such, an Innovation project should provide new knowledge to inform current and future mental health practices and approaches, and not merely replicate the practices/approaches of another community.

Section 1: Innovations Regulations Requirement Categories

CHOOSE A GENERAL REQUIREMENT

An Innovative Project must be defined by one of the following general criteria. The Proposed project:

- ☐ Introduces a new practice or approach to the overall mental health system, including, but not limited to, prevention and early intervention
- ☐ **Makes a change to an existing practice in the field of mental health, including but not limited to, application to a different population**
- ☐ Applies a promising community driven practice or approach that has been successful in a non-mental health context or setting to the mental health system
- ☐ Supports participation in a housing program designed to stabilize a person's living situation while also providing supportive service onsite

CHOOSE A PRIMARY PURPOSE

An Innovative Project must have a primary purpose that is developed and evaluated in relation to the chosen general requirement. The proposed project:

- ☐ Increases access to mental health services to underserved groups
- ☐ Increases the quality of mental health services, including measured outcomes
- ☐ **Promotes interagency and community collaboration related to Mental Health Services or support of outcomes**

- Increases access to mental health services, including but not limited to, services provided through permanent supportive housing

Section 2: Project Overview

PRIMARY PROBLEM

What primary problem or challenge are you trying to address? Please provide a brief narrative summary of the challenge or problem that you have identified and why it is important to solve for your community. Describe what led to the development of the idea for your INN project and the reasons that you have prioritized this project over alternative challenges identified in your county.

San Luis Obispo County lacks a coordinated and collaborative training model and system to assess and intervene as necessary with school-based threats. In 2014, the FBI released *A Study of Active Shooter Incidents in the United States Between 2000 and 2013*, which reviewed 160 incidents involving an individual who attempted to kill people in a confined/populated area. Only twelve incidents, or 7.5%, occurred at institutions of higher education; however, nearly one quarter of the incidents studied occurred at educational settings and these accounted for some of the highest casualty counts. The individuals who engaged in violence included students, former students, employees, and a visitor (Blair & Schweit, 2014). The report also contains information regarding incidents occurring at commerce and employment settings, which may have relevant findings for the San Luis Obispo community.

The Center for Homeland Defense and Security's K-12 School Shooter data base (www.chds.us) indicates that in 2018, there have been 92 school shooting incidents, double the number of incidents for 2016 and 2017, with the most frequent ages of the perpetrator has been 16 and 17 years. Thus, incidents, nationally, are increasing. More recently, there have been incidents that have occurred locally and regionally. These have included the following incidents as captured by headlines:

1. A 17 year old Morro Bay High School student was arrested this week on suspicion of making threats against the school, police say. March 26th, 2018.
2. Atascadero High student threatened to 'shoot up' school. March 14th, 2018
3. Islay Vista Mass Murder, May 23, 2014
4. Individual in mental health therapy makes a threat toward Ventura Schools. www.vcstar.com/story/news/education/2018/08/29/ventura-unified-school-district-potential-threat-parents
5. Borderline Bar and Grill Shooting, Thousand Oaks, CA November 7th, 2018

Although threat assessments and monitoring have become a staple practice in educational institutions, recent case study reviews have noted that isolated, inconsistent, and ineffective implementation of threat assessment and monitoring can leave educational institutions vulnerable to violent incidents (Goodrum et. al 2018, White 2017). With the increasing, ongoing threats and lack of a coordinated and collaborative model system, San Luis Obispo County is at a disadvantage to assess and engage youth in these situations.

Presently, none of the educational, law enforcement or educational institutions have a regular data base that monitors the number of threats made, whether low level or of higher level, type of threat, and by whom, that warrants a multi-agency response. San Luis Coastal Unified provided the following

information based upon a review of threat assessment reports from the past several years. These cases are frequencies and presented in a range as each year may differ.

High Level Threats	Requiring Multi-Agency Response	Requiring Mobile Crisis or Hospitalization	Amount of Staff Time (Paperwork and Follow-up)	Ongoing Monitoring
9-12 per year	2-4 per year	2-3 per year	2-3 weeks	2 months

It should also be noted that there have been several cases in the last 5 years that have required multi-agency involvement with one including FBI involvement involving a student and parent.

Cal Poly noted that the university nor campus police track data related to threats on campus. There is not a formal threat assessment team and level, type of threat, and threat source are not obtained. Administrators indicated that they have had 4 high level cases in the past 3 years. One situation involved a student making a bomb threat on a public bus. Another involved a student making several via email and verbal statements in classrooms over a 2-year period. Another involved an employee making a threat to another employee which also involved stalking.

Finally, a student made several threats against a political speaker who was coming to campus. This garnered the involvement of the FBI. An out-of-state, private and price prohibitive Threat Assessment was conducted. Although the student was expelled, charges made, and treatment recommended, the individual remained in the community. There was not a specific recommendation or guidance from the Threat Assessment Report about how local agencies should continue to monitor for potential threats from the individual.

PROPOSED PROJECT

Describe the INN Project you are proposing. Include sufficient details that ensures the identified problem and potential solutions are clear. In this section, you may wish to identify how you plan to implement the project, the relevant participants/roles within the project, what participants will typically experience, and any other key activities associated with development and implementation.

A) Provide a brief narrative overview description of the proposed project.

The project is designed to develop a coordinated and collaborative training model and system to learn, assess, and intervene when cases of threat become apparent or imminent. The innovation project is also designed to create a new learning and language model between the mental health system (MHS), law enforcement (LE), and educational institutions (EI) employing a new curriculum derived from proven and effective models, but tailored to San Luis Obispo and directed to the coordinating efforts between MHS, LE, and EI. The innovation project is meant to educate and decrease the criminalization and stigmatization of youth in cases of threats.

Through education and ongoing training, community partner teams and the public involved in the referral, assessment, and monitoring of threats will learn the psychological, behavioral, social, and familial signs strongly associated with threatening behavior. With further education, the teams will begin to recognize components of threatening behavior that may likely have a mental health treatment response. This will refocus community partners toward prevention and intervention responses rather than prosecution.

Key Components:

Development and Implementation of a SLO-centric threat assessment model in county-Examine Community Model

The project builds a unique model upon examining diverse approaches to threat assessment and creating protocols to identify, manage threats of target-based violence, and follow-through. Threat Assessment Teams can implement preventative strategies to school, campus, workplace, or community violence.

Collaboration and training

The project creates a system of collaboration and experts trained in the new threat assessment process based on a multi-disciplinary team approach from various backgrounds (education, mental health, and law enforcement) employing fact-based predictors of violence, and applying an individualized and preventative approach. A single model across multiple-agencies creates a common language that allows for expedient and clear communication.

Educating the Community-Students, Parents, Mental Health Professionals and CBO's.

This process requires educating students, parents, school employees, coworkers, supervisors, etc. on how to identify behaviors that may reveal an individual's potential intent to do harm to others and leading and achieving the process to make a referral. Referrals are provided by the following process, 1) assess the components, 2) manage of threats, and 3) obtain appropriate mental health support if warranted. By educating community individuals on making specific referrals, this likely prevents a situation in which information and knowledge slips through the system. Education empowers community stakeholders to report information to appropriate persons to initiate a Threat Assessment Process. Teachers, parents, school officials, mental health professionals, employers, etc. must be aware of individuals who exhibit warning behaviors that signal profound psychosocial distress.

Mental Health Capacity Building

Development of a community-based system to receive reports from the community, accurately assess the potential violence, and respond with appropriate support strategies to stabilize and mitigate the threat. Finding the proper therapeutic intervention approach (inpatient hospitalization, medication, family therapy, CBT) as well as monitoring potential reduction in violence.

B) Identify which of the three project general requirements specified above [per CCR, Title 9, Sect. 3910(a)] the project will implement.

The current proposed project aims to make a change to an existing practice in the field of mental health, including but not limited to, application to a different population.

C) Briefly explain how you have determined that your selected approach is appropriate. For example, if you intend to apply an approach from outside the mental health field, briefly describe how the practice has been historically applied.

Threat Assessment Teams are presently operating to some level in the San Luis Obispo County, yet there is not a coordinated and collaborative system and model focused on assessment approaches, access to school resource officers, and mental health treatment and engagement. Historically, research has indicated that K-12 districts campus-based or university-based systems have run their threat assessment and threat responses in isolation either in their assessments, law enforcement responses, or mental

health intervention. A direct collaborative system and integrated model has yet to been put in place. By creating an integrated system, all agencies involved will gain a holistic understanding the psychological, social, and family components that might explain the result of the threat behavior. This, in turn, will lead to a focus on variables needing intervention and prevention rather than highlighting only the threatening behavior for discipline.

D) Estimate the number of individuals expected to be served annually and how you arrived at this number.

Approximately 50 participants every fiscal year will be part of the Innovation Project, which will include participants from the Mental Health field, Law Enforcement, and Educational Institution staff.

E) Describe the population to be served, including relevant demographic information (age, gender identify, race, ethnicity, sexual orientation, and/or language used to communicate)

The participants will be Mental Health Professionals, Law Enforcement, Educational Institution Staff. A large sample will be drawn from the County to cover all regional areas.

RESEARCH ON INN COMPONENT

A) What are you proposing that distinguishes your project from similar projects that other counties and/or providers have already tested or implemented?

Unlike the START Program from LA County, which is a centralized comprehensive program in a large urban area, the SLOTAP Program proposal aims to develop at tiered system within in a mostly provincial area with limited access to resources by creating a SLO-centric training model that supports a coordinated and collaborative system and model between MHPs, LE, and EI staff.

B) Describe the efforts made to investigate existing models or approaches close to what you're proposing. Have you identified gaps in the literature or existing practice that your project would seek to address? Please provide citations and links to where you have gathered this information.

There are Threat Assessment programs and models that are in place, but there is not a specific training model targeted to MHPs, LE, and EI staff to work in a coordination to address, assess, intervene, and provide services as described by the innovation project.

LEARNING GOALS/PROJECT AIMS

The broad objective of the Innovative Component of the MHSA is to incentivize learning that contributes to the expansion of effective practices in the mental health system. Describe your learning goals/specific aims and how you hope to contribute to the expansion of effective practices. (See Attachment 1)

A) What is it that you want to learn or better understand over the course of the INN Project, and why have you prioritized these goals?

The Innovation Project's goals/aims are the following:

1. Provide Stakeholder/Participant Training - The County and its stakeholders hope to learn more about the best approaches for teaching and training of threat assessment procedures for MHPs, LE, and EI staff in a community with limited resources.
2. Develop a Community Threat Assessment System - The County and its stakeholders seek to understand the best components that make an efficient, coordinated, and collaborative system and model related to threat assessment.
3. Community Education and Outreach on Warning Signs - The County and its stakeholders seek to learn better methods to increase prevention and early detection and engagement as it relates to threat assessment.
4. Increase Knowledge of Mental Health Intervention Approaches - The County and its stakeholders seek to better understand how MHP should approach and treat individuals or students who have made threats or gestures towards homicidal violence.

The Innovation Project's objectives/metric outcomes are the following:

a) Increase the level of skill and knowledge for MHPs, LE, and EI staff to identify and prevent school and community threats as defined and assessed by a training model.
    1) Metrics include number of pre/post retrospective surveys, testing objective and training/consulting expert progress reports will be collected. A Multiple-Choice Pre-test of the adopted Threat Assessment Principles will be conducted.

a) Increase the level of interagency collaboration through the development and use of the coordinated and collaborative training system and model for threat assessment.
    1) Metrics include documentation of interagency meetings, case review questionnaire, number of coordinated collaborative threat assessments, awareness of potential stereotypes via reflections and open-ended responses, and communication assessment between interagency SLOTAP team

a) Decrease the number and level of potential threats identified through referral.
    a. Metrics include the number of threats and their levels before the participants attend training and after the participants attend training. The number of threat referrals and source of referral (parent, teacher, student, etc.)

a) Increase the number of MH professionals available to provide therapy to individuals who make serious threats.
    a. Metrics include documented training and presentations to MH professionals on threat assessment process, pre/post survey of MH professionals receiving referrals, number of referrals provided to MH professionals based upon threat assessment recommendations.

B) How do your learning goals relate to the key elements/approaches that are new, changed or adapted in your project?

These learning goals are directly related to the innovative components previously described, namely, the testing of a new and never-before designed, coordinated, and collaborative training system and model focused on threat assessment.

EVALUATION OR LEARNING PLAN

For each of your learning goals or specific aims, describe the approach you will take to determine whether the goal or objective was met. Specifically, please identify how each goal will be measured and the proposed data you intend on using.

The Innovation Project will collect the following data for each goal:

1. The number of each participants involved in training or workshops
2. The number of threat assessments conducted, including type of threat, and level of threat
3. The number of mental health referrals provided during the training period stemming from threat assessments
4. The number of case consultation conferences held annually
5. Pre and post assessment/evaluations conducted after each training process
6. Case Review Questionnaires

Section 3: Additional Information for Regulatory Requirements

CONTRACTING

If you expect to contract out the INN project and/or project evaluation, what project resources will be applied to managing the County's relationship to the contractor(s)? How will the County ensure quality as well as regulatory compliance in these contracted relationships?

The County plans to select a contract provider who will best execute this project. The County has outstanding contractual partnerships across the community mental health system, as well as strong relational partnerships with many community schools, colleges, health providers, and law enforcement agencies. The Behavioral Health Department, including the MHSA Administrative Team, is well equipped to conduct a fair and successful procurement process (in partnership with County Purchasing) and expedite a contract to be sure Innovation timelines presented herein are met.

The County Innovation Component Coordinator, Nestor Veloz-Passalacqua (Administrative Services Officer II), is the community liaison for all Innovation (and PEI) projects and evaluation. Nestor coordinates the stakeholder planning process and will be the one to develop any RFP to select providers. The MHSA Administrative Team also includes Frank Warren (Division Manager), the County MHSA Coordinator, who manages all aspects of MHSA, including contracts and plan monitoring. Briana Hansen, Accountant III, is the fiscal lead and works with each provider to develop accurate budgeting and spending plans. Kristin Ventresca, the CSS Coordinator (Administrative Services Officer II), also provides contract management and oversight. Nestor uses California Polytechnic State University statistics and public policy students in paid internships that assist in data collection, technical assistance for providers, and reporting.

All Innovation providers will meet regularly with Nestor and the team before and during the start-up phase to finalize plans, conduct data collection tests, and develop tools. Some plans may need to be adjusted

(based on hiring, procurement of materials, etc.) and Nestor will work with each contractor to provide support and guidance to keep the projects on time. After the launch of each project, Nestor will work with the contractors to provide quarterly reports and data collection. The MHSA Administrative Team will conduct spot checks, review project materials, and review quarterly reports to ensure quality and regulatory compliance.

Additionally, the County will establish a contract with an Evaluator to manage the analysis of data, as well as provide technical assistance to the projects to be sure tools are developed which accurately measure the results of each objective. This Evaluator will provide regular reports to the MHSA Administrative Team and MHSA Advisory Committee (stakeholder group), as well as the final report which will be provided to the MHSOAC.

COMMUNITY PROGRAM PLANNING

Please describe the County's Community Program Planning process for the Innovative Project, encompassing inclusion of stakeholders, representatives of unserved or under5 served populations, and individuals who reflect the cultural, ethnic and racial diversity of the County's community.

A new round of innovation was launched in October 2018. The first Innovation Stakeholder meeting took place in October 11, 2018 where new and current Innovation Stakeholders were present to review the innovation guidelines and begin a larger conversation and collaboration process for research and testing new meaningful ideas in our community. Community members ranging from psychologists, to educators, and think tank individuals were present as well as mental health providers and partners. The County made available information containing steps to successfully submit an innovation idea, along with providing technical assistance in developing the narrative piece of the proposal. Once of the most eager and profoundly interested community members was Dr. Joseph Holifield. At an initial meeting he presented the first iteration of his idea to integrate and develop a new coordinated and collaborative training model and system to learn, assess, and intervene when threats become apparent or imminent in the educational system. Dr. Holifield had based his idea from years of performing threat assessments and leading threat assessment teams in several local school districts (2000-2017). He blended his experience with new information about community-based models discussed at a recent Threat Assessment Conference he attended in August of 2018. Dr. Holifield had also taught at Cal Poly for 15 years (2000-2015) and School Shootings were a topic he covered in one of his lectures. After each lecture, several students would typically approach him about ongoing concerns they had about students on campus. He recognized, at that time, there was not an internal system of review for threats. Based upon his academic knowledge and experiences with threat cases, he recognized that the community had a fragmented approach to threat assessment. With this in mind, Dr. Holifield took it upon his own volition to reach out to community partners he previously had been involved. By working privately outside of each system, he wanted to devote his time to assist in developing a system that would work for both community partners as well as bring other agencies such as law enforcement and mental health to the table for a collaborative project. Having practiced in the San Luis Obispo Community for 19 years, he also understood the current limitations in the community with regard to mental health support for individuals who present with these issues.

This project is part of larger collaboration between local organizations around the creation of a coordinated and collaborative training system and model to best approach, treat, assess situations threat in our community. The project continued to be refined as County staff, Dr. Holifield, California Polytechnic State University, and school district representatives were involved. The project design is the result of

community engagement led by Dr. Joseph Holifield with local School Districts. Additionally, the Behavioral Health Department has provided support in the form of technical assistance to best refine and coordinate efforts to make the proposal a priority in reference to what the community needs are. Additional interest in implementation and processes came from California Polytechnic State University – San Luis Obispo. The project design became apparent as feedback included the need to build a training system and infrastructure to allow for better engagement and response to threats that are present in the community, leading to assist youth and college students being connected to mental health services and a recovery process before a threat is made present. The County continues to provide technical assistance and support in the development of the proposal, as well as providing procedural information to the development and completion of the proposal. The continued collaboration between stakeholders, community members, and advocates stems from understanding the dire need to ensure a coordinated and collaborative training approach bring in MHPs, LE, EI staff together to address and deescalate threat situations, while providing youth with an opportunity to feel better engaged and to help them experience success and mental health wellbeing.

The innovation project team has solidified their efforts with Dr. Holifield. School districts, Cal Poly, and stakeholders to emphasize and coordinate proper coordination and implementation of the proposal. The staff and appropriate partners, such as Dr. Holifield, school district representatives, and other stakeholders will continue to meet regularly during the project development, implementation, and evaluation to identify and address challenges, and to coordinate proper engagement for the intervention being tested. Currently the County Innovation Coordinator has received feedback from the Mental Health Services Oversight and Accountability Commission (MHSOAC) to ensure Innovation guidelines and regulations are met. The feedback and edits have been implemented into the proposal. Part of our efforts for a successful proposal includes the continued collaboration and coordination with the County and community-based organizations to ensure the inclusion of a wide representation of staff, and to ensure planning efforts reflect the community collaboration and the impact on the youth population.

MHSA GENERAL STANDARDS

Using specific examples, briefly describe how your INN Project reflects, and is consistent with, all potentially applicable MHSA General Standards listed below as set forth in Title 9 California Code of Regulations, Section 3320 (Please refer to the MHSOAC Innovation Review Tool for definitions of and references for each of the General Standards.) If one or more general standards could not be applied to your INN Project, please explain why.

A) Community Collaboration

The project is designed upon a stronger collaboration that includes youth, Law Enforcement, the County Probation Department, Educational Institutions (K-12 schools and Higher Education), County Behavioral Health Department, and family and community members. The project fosters and maintains community collaboration through a process of consistent stakeholder advisory group interaction representing diverse racial/ethnic, cultural, and linguistic communities. The project works with mental health providers, law enforcements, a regional university, school district staff, families, parents/caregivers, and other professionals to enhance and develop an appropriate training model to best identified threats.

B) Cultural Competency

The project is designed to impact diverse communities from all regions of the County. The project employs culturally and linguistically appropriate staff that will engage clients in service delivery that fosters equal

access to services without disparities. Additionally, the stakeholder advisory group incorporates into the project design culturally and linguistically appropriate guidance in the administration, implementation, delivery, and evaluation processes. This will be achieved by providing participants with opportunity to participate in the project and by providing all services in the primary language of the participant. Services will engage and retain diverse individuals through recruitment by a trusted source. The stakeholder advisory group will monitor the project for disparities in services using process data and community data provided by the project data analyst.

C) Client-Driven

The project is designed to engage MHPs, LE, EI staff that work primarily with youth, who are ultimately the population that will be impacted by the Innovation project. Youth's and college students' experiences and information will provide guidance and better understanding to the participants on what best practices and approaches are available to identify and engage with youth who may be part of a threat.

D) Family-Driven

The project is designed to engage the participants within the youth and their direct family support network as the primary agents of information. Their involvement will determine decisions as well as what elements of the coordinated and collaborative training system and approach are essential to identify potential threats and how to appropriate respond to them.

E) Wellness, Recovery, and Resilience-Focused

The project services maintain the philosophy, principles, and practices of the Recovery Vision. Early intervention often prevents or mitigates behavioral and social problems; therefore, early referrals and connection to mental health resources and supports are a focus of the project. Youth and parental empowerment and social connections are critical to the youth's well-being and are supported through offering community information to access services.

F) Integrated Service Experience for Clients and Families

The project involves an integrated community approach and resource knowledge experience. Project partners and staff work on providing a seamless system between County agencies and community providers as a referral source is available to youth to create a larger system of mental health care coordination.

CULTURAL COMPETENCE AND STAKEHOLDER INVOLVEMENT IN EVALUATION

Explain how you plan to ensure that the Project evaluation is culturally competent and includes meaningful stakeholder participation.

The cultural competence goals have been incorporated into the project design and will be included in the project administration, delivery, and evaluation. Equal access to services without disparities will be achieved by providing all participants with equal opportunity to participate in the project and by providing the test in the primary language of the participant. The stakeholder advisory group will monitor the project for disparities in services using process data and community data provided by the project data analyst; adjustments will be immediately made to eliminate any disparities found.

INNOVATION PROJECT SUSTAINABILITY AND CONTINUITY OF CARE

Briefly describe how the County will decide whether it will continue with the INN project in its entirety, or keep particular elements of the INN project without utilizing INN Funds following project completion. Will individuals with serious mental illness receive services from the proposed project? If yes, describe how you plan to protect and provide continuity of care for these individuals upon project completion.

The costs associated are for training program development and coordination, initiation, ongoing operation, and evaluation. If the evaluation indicates the coordinated and collaborative training system and model is effective, the County will work collaboratively with MHPs, LE, and EI staff, and other important youth-oriented and campus organizations that have been part of the project to help determine the best public and private funding sources to continue this service, and the challenges and success of the project as informed by evaluation results.

COMMUNICATION AND DISSEMINATION PLAN

Describe how you plan to communicate results, newly demonstrated successful practices, and lessons learned from your INN Project.

A) How do you plan to disseminate information to stakeholders within your county and (if applicable) to other counties? How will program participants or other stakeholders be involved in communication efforts?

There are several ways we plan to continuously disseminate information to stakeholders, including:

- Holding a final report forum, sponsored by the project's Stakeholder Advisory Committee
- Use of social media and outreach with organization focused on youth-development
- Partner newsletters and local media
- Presentations to partner boards of director and county leaders
- Holding semi-annual case review conferences among trainees to review training practices related to the adopted threat assessment model or approach.

Stakeholders will be involved through the planning, implementation, and evaluation of the project, as well as additional quarterly reporting meetings. Program participants will be invited at every possible opportunity to take part in sharing findings through written testimonials, participant feedback, and/or public presentations of findings. It is these real stories of real experiences that are most impactful.

B) KEYWORDS for search: Please list up to 5 keywords or phrases for this project that someone interested in your project might use to find it in a search.

SLOTAP, Mental Health, Campus, Threat, Assessment

TIMELINE

A) Specify the expected start date and end date of your INN Project

The Innovation Project is expected to start on July 1, 2019 and will end on June 30, 2023.

B) Specify the total timeframe (duration) of the INN Project

Four years starting October 2019 – October 2023

C) Include a project timeline that specifies key activities, milestones, and deliverables—by quarter.

The success of the Innovation project is predicated upon the professional administration, coordination and collaboration amongst the implementation team, stakeholders, advisory committee, contractors, and experts to thoughtfully oversee the project. The County will be prepared to successfully put into place the major elements of the project in the six-month ramp-up, the intervention/testing period, and the six-month evaluation phase.

Ramp up/Planning: July - December 2019

- Develop and finalize the curriculum
- Plan and solidify implementation logistics
- Contract with speakers/subject expert matters/trainers
- Develop data collection tools
- Coordinate delivery and training schedule

Year One Major Milestones

- Begin the first Team Class with MHPs, LE, and EI staff
- Year-end report discussion with stakeholder advisory committee

Year Two Major Milestones

- Graduation of first Team Class
- Begin the second Team Class with MHPs, LE, and EI staff
- Review and consider results of first team class evaluation and next steps to solidify new lessons learned or revise curriculum
- Year-end report discussion with stakeholder advisory committee

Year Three Major Milestones

- Implementation of recommended pieces as discussed in year one and year two, if applicable
- Graduation of second Team Class
- Begin the third Team Class with MHPs, LE, and EI staff
- Year-end report discussion with stakeholder advisory committee

Ramp down/Evaluation: January - July 2023

- Review all evaluation done to date and implement any additional evaluative tool
- Collaborate with the Research Partner to publish results of the study
- Secure funding needed for replication if optimal teen health model proves successful
- Hold a project end forum to discuss lessons learned, sponsored by the stakeholder advisory group

What is listed above are only a few of the major milestones. Already, this project begins as a partnership amongst several organizations. As it moves forward, a significant emphasis will be to genuinely engage multiple groups and individuals at each step. The County sees this as the best approach to gain valuable information to better serve the community.

Section 4: INN Project Budget and Source of Expenditures

INN PROJECT BUDGET AND SOURCE OF EXPENDITURES

The next three sections identify how the MHSA funds are being utilized:

A) **BUDGET NARRATIVE (Specifics about how money is being spent for the development of this project)**
B) **BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY (Identification of expenses of the project by funding category and fiscal year)**
C) **BUDGET CONTEXT (are MHSA funds being leveraged with other funding sources?)**

BUDGET NARRATIVE

Provide a brief budget narrative to explain how the total budget is appropriate for the described INN project. The goal of the narrative should be to provide the interested reader with both an overview of the total project and enough detail to understand the proposed project structure. Ideally, the narrative would include an explanation of amounts budgeted to ensure/support stakeholder involvement (For example, "$5000 for annual involvement stipends for stakeholder representatives, for 3 years: Total $15,000") and identify the key personnel and contracted roles and responsibilities that will be involved in the project (For example, "Project coordinator, full-time; Statistical consultant, part-time; 2 Research assistants, part-time…"). Please include a discussion of administration expenses (direct and indirect) and evaluation expenses associated with this project. Please consider amounts associated with developing, refining, piloting and evaluating the proposed project and the dissemination of the Innovative project results.

Personnel Expenditures
There will be up to 2 interns from the Cal Poly Psychology Department that will participate in data collection, outcome data entry, and will provide additional support with regard to research and development data-based forms. There will be no cost as students will be gaining experience and obtaining course credit for their participation. (Up to 10 hours a week)

Rent/Lease Building: Prorated cost of Threat Assessment Manager's Office to conduct SLOTAP business. Rent is part of an adjusted modified gross lease with basic utilities included such as garbage pick-up, and other utilities (electric, gas, water, etc.). Address is located at 11549 Los Osos Valley Road, Suite 200, San Luis Obispo, CA 934005. The prorated cost is adjusted base on yearly rent increase within the lease as well as increase in time space is utilized by Threat Management Coordinator.

Year 1- $950/month X .50 (20 hours/week)= $475.0/month prorated X 12 months=$5,700
Year 2-$988/month X .30 (hours/week)= $741.0/month prorated X 12 months=$8,892
Year 3-$1,028/month X .75 (30 hours/week)= $771.0/month prorated X 12 months=$9,252

Year 4-$1,069/month X .80 (32 hours/week))= $855.0/month prorated X 12 months=$10,262

Utilities/Internet: Business Internet/Phone-Prorated at same rent schedule at hours/week
Office Internet Connection and cell phone
Year 1=$31.25/month X 12=$375
Year 2=$37.50/month X 12=$450
Year 3=$37.50/month X 12=$450
Year 4=$46.87/month X 12=$562.40

Phone/Fax—Add-on
$30/month extra added on to the internet provider
Years 1-4 ($360/year X 4 Years=$1,440

Internet Research Access: Years 2-4
APA PsycINFO will be shifted to this line item after the first year.

Non-Recurring Expenditures:

Office Furniture and Tools
Laptop/Chromebook-$600
SLOTAP will make a one-time purchase of a laptop/Chromebook to utilize to conduct program activities and communication via email. This purchase also includes a subscription to Microsoft Windows-Research that would include Word, Excel, PowerPoint, Access

Printer-$450
One time purchase of a basic color laser printer for the program.

Filing Cabinet-$200
Filing Cabinet for storage of hard copies of program records and activities.

Office Phone-Business Phone-Conference Phone Capabilities-SLOTAP Program-$175

Research and Threat Assessment Tools:

American Psychological Association (APA)-PsycINFO®
Centered on psychology and the behavioral and social sciences, the interdisciplinary content in PsycINFO® makes it one of the most highly utilized databases by students, researchers, educators, and practitioners worldwide, and an indispensable tool for the discovery of global scholarly research. With more than 4 million records and upwards of 4,000 expertly-indexed records added each week, this ever-expanding collection of behavioral and social science research, dissertations, and scholarly literature abstracts offers a broad view of the field. Abstracts included with all dissertation records since 1995, and nearly all records from 1967 to present**.** The use of this tool will allow the Threat Management Coordinator to research and review scholarly articles that will assist in the design and refinement of threat assessment and intervention support to community partners and mental health professionals.

Cost:
Annual Subscription-$140 for APA Members
$560 through the life of the Grant

WAVR-21 3rd Edition- University and Mental Health Focused

Source: www.wavr21.com

The WAVR-21 is among the growing number of "structured professional judgement guides ("SPJs"). The WAVR-21 is not a psychological test or scale, and does not generate a quantitative "score." However, the WAVR-21 exemplifies the growing trend in risk assessment technology toward the use of SPJs. In this organized but non-quantitative format, responders refer to a list of factors, each of which has some form of coding criteria with a demonstrated relationship to violence. Such guidelines improve the consistency and transparency of assessment decision-making. Other structured guides exist to assess the violence risk associated with psychopathy, spousal abuse, stalking, released violent offenders, sex offenders, youth offenders, and discharged mental patients. SPJs are also generally prescriptive: they identify interventions and actions to manage and mitigate a subject's possible violence risk.

1) *The primary focus of the WAVR-21 is to assess the risk of workplace or campus homicidal targeted violence.* A term originally coined by the behavioral scientists of the US Secret Service, targeted violence refers to situations in which an individual intentionally commits an act of violence against an identified or symbolic target, whether people or places. Also referred to as *intended* violence, these acts are potentially foreseeable, as they are the result of an understandable, evolving and often discernable process of thinking, behavior, and preparation. Several of the WAVR-21 factors incorporate this "pathway to violence" escalation dynamic.

2) *The secondary purpose of the WAVR-21 is to capture other forms of problematic aggression.* The WAVR may be used to identify and assess the risk, frequency, and severity of non-homicidal aggression such as stalking, disruptive anger problems, menacing behavior and bullying. These manifestations of aggression are common and problematic in organizational settings in themselves, and could also figure into the ultimate formulation of a subject who may pose a risk of targeted homicide. This view is consistent with contemporary theories that targeted violence is continuous, contextual, and dynamic.

3) *The item domains of the WAVR include both static and dynamic factors*. The WAVR items include psychological, behavioral, historical, and situational factors associated with targeted violence, including intimate partner violence posing a threat to a workplace or campus. In practice, threat assessment and threat management are intertwined. Dynamic risk factors (e.g., acute psychosis, access to weapons or targets) become the focus of interventions intended to reduce risk. Assessment and monitoring are ongoing, and an individual's response to various interventions (e.g., escalation, de-escalation, or no apparent change) become part of the changing opinion of risk level.

Cost:

One Time Manual and Tool Kit- $199.00
25 Additional Protocols/Forms- $ 65.00
Team User Training - $2,500.00

SAVRY-K-12 and Mental Health Focus

Source: Psychological Assessment Resources (PAR)- https://www.parinc.com

The SAVRY is composed of 24 items in three risk domains (Historical Risk Factors, Social/Contextual Risk Factors, and Individual/Clinical Factors), drawn from existing research and the professional literature on adolescent development as well as on violence and aggression in youth.

Features and benefits

- Based on the structured professional judgment (SPJ) model, the SAVRY helps you structure an assessment so that important factors will be emphasized when you formulate a final professional judgment about a youth's level of risk.
- Addresses the primary domains of known risk and protective factors and provides clear operational definitions. Risk and protective factors are based on their relationship to adolescents—not to children or adults.
- Not designed to be a formal test or scale, there are no assigned numerical values or specified cutoff scores.
- Both reactive and proactive aggression—aggression subtypes that are extensively theoretically supported—are emphasized.
- Items have direct implications for treatment, including the consideration of dynamic factors that can be useful targets for intervention in risk reduction.

Test structure

- Each risk item has a three-level rating structure with specific rating guidelines.
- Six protective factor items are rated as either present or absent.

Contracts

Trainers and Consultants:

Threat Management Coordinator: The Threat Management Coordinator is responsible for the overall effectiveness of all aspects of the program. Through the recommendations of expert trainers, the Threat Management Coordinator is responsible for the development of the community threat processes and guidance of community teams. In addition, along with MHSA Innovation Team, the Threat Assessment Coordinator will be responsible for the development, collection, and evaluation of various components of the SLO-TAP program.

The Threat Management Coordinator will also be responsible for:

1) Coordinating and scheduling trainings for community partners from expert consultants
2) Developing presentations and local trainings with community partners (Educational Institutions, Law Enforcement, and Mental Health)
3) Assistance with Threat Assessment Team Design with Community Partners.
4) Outreach and recruitment of professionals within community partner agencies to receive additional training and become within agency experts
5) Consulting with Community Partners regarding Threat Assessment Design and Procedures. Assists with various aspects paperwork, procedures, partner meetings, etc.

6) Threat Consultation for Community Partner Teams, either in person, via phone, or by encrypted HIPAA compliant Telehealth platform. Issues beyond the scope of training of the Threat Assessment Coordinator, will be directed to the Clinical Threat Management Expert for further consultation and response.

7) Under the supervision of the Community Threat Expert, assist in the design, implementation, and coordination of a community threat assessment program.

8) Provide community trainings to students, parents, faculty/staff about Threat Assessment Process

9) Explore intervention approaches that may be efficacious to treatment of individuals who make threats.

10) Outreach, networking, and recruitment of mental health professionals to be trained in the basic components of the Threat Assessment Process.

11) Consult and collaborate with community mental health professionals on intervention design and response to intervention for individuals receiving therapy due to psychological and social variables that led to a threat being made.

12) Coordination, assignment, and supervision of work responsibilities or student interns other personnel designated to perform activities associated with the SLOTAP Project.

The Threat Management Coordinator position will initially be part-time consultant position. The goal at the end-of-the grant period is that a full-time community position will be supported by either the County of San Luis Obispo or consortium of community partners. The proposed salary schedule is as follows:

$130/hour starting at 10 hours a week the first year, increasing to 12 hours for Year 2 and Year 3, and ending at 15 hours a week for the final year of the grant. ($62,400 to $93,600). This rate is approximately 1/3 the median rate of $350/hour for a threat assessment professional.

Clinical Threat Management Expert:

The role of the Clinical Threat Management Expert is to provide on-site training and mentoring for the Threat Management Coordinator and SLOTAP community partners threat teams or designated threat professionals. The Clinical Threat Management Expert should be certified as a Certified Threat Manager through the Association of Threat Assessment Professionals. If involved in case consultation for a threat deemed high level, the Clinical Threat Management Expert will report to and work directly with the Threat Management Coordinator in consulting with the community partner teams.

Through the guidance of the Clinical Threat Management Expert and/or Threat Management Coordinator, community partner teams will have the opportunity to complete threat assessments side-by-side with the local Threat Management Coordinator and/or clinical expert. They will work side-by-side with community partner staff as they work with threat assessments in the replication of strategies and expertise modeled by the Clinical Threat Management Expert or through the Threat Management Coordinator at the guidance of the Clinical Threat Management Expert. The Clinical Threat Management Expert will assist SLOTAP in the initial design and community partner team training programs and on-going clinical case reviews. The Clinical Threat Expert can be available for case consultations as well as to assist in the design of clinical forms, clinical reports, and clinical recommendations.

Onsite Clinical Training Workshops
The Clinical Workshops are designed to enhance the clinical knowledge and skills of practitioners from a broad spectrum of specialties (Education, Law Enforcement, Mental Health). Participation in the Clinical Workshops will be designed to increase site and SLOTAP staff in the ability to provide direct services to children and families affected by substance abuse and to serve as community leaders in the integration of services and systems for women, children and families. A maximum of 20 participants at a time attend a full and one-half-day program, and through their participation are able to replicate the strategies and expertise developed. Money is also allotted for a refresher course in the third year of the grant program.

Training: Includes workshops, handouts, materials provided by trainer
Travel: Travel cost for the expert includes: airfare, hotel, transportation, food.
Consultation: Expert clinical consultation (threat cases, forms, clinical procedures, review of team threat assessment reports and feedback etc.) available to Threat Management Coordinator and with Community Partner Team Members

Costs
The fee for a 1 to 2 day site clinical training is $8,000-$10,000
Refresher Workshop (if needed Year 3--$6,000)
Clinical consultation (Clinical Consultant Rate=$350/hour). Consultation can occur in-person, phone, video-feed, or email.
Year 1-up to 4 hours month=48 hours Annual Total =$16,800
Year 2- up to 5 hours month=60 hours Annual Total =$21,000
Year 3-up to 4 hours month=48 hours Annual Total=$16,800
Year 4-up to 2 hours month=24 hours Annual Total=$8,400

Community Threat Expert:

The role of the Community Threat Expert will be to work with the Threat Management Coordinator and community partner administrative team in the planning and development of policies and procedures geared towards the coordinated effort of threat assessment, threat management, intervention, and threat monitoring. This is not an easy approach, since our county will be moving away from a purely single agency approach and towards an integrated and collaborative paradigm. The Community Threat Expert will assist in guiding the Threat Management Coordinator and Community Partners in reviewing current community systems that presently may interact or may be fragmented when a serious threat is made. The Community Threat Expert will guide and assist the Threat Management Coordinator and Community Partners in the design and implementation of a community-based threat assessment approach that integrates multiple systems (education, mental health, law enforcement) that serves to intervene and prevent individuals from carrying-out an imminent, large scale threat to commit harm towards students, faculty, staff, and parents in San Luis Obispo County.

Costs:
The fee for a 1-2 day community partner training and initial community consultation is estimated to be $7200

Community Expert consultation (Consultant Rate=$250/hour). Consultation can occur in-person, phone, video-feed, or email.

Year 1-up to 2 hours month =up to 24 hours Annual Total =$6,000
Year 2- up to 1 hour month=up to 12 hours Annual Total =$3,000
Year 3-up to 2 hours month=up to 24 hours Annual Total=$6,000
Year 4-up to 1.5 hours month=up to 24 hours Annual Total=$4,500

Other Expenditures

Conferences

Money will be available for selected Community Partner Team members from EI, LE, or MH to attend conferences or participate in webinars focused on threat assessment topics. Organizations such as NaBITA (www.nabita.org) and Association of Threat Assessment Professionals (ATAP- www.atapworldwide.org) are directly focused on threat assessment and threat management. Other organizations such as American Psychological Association (APA) and National Association of School Psychologist (NASP) may have focused workshops or presentations that may be related.

The purpose is to develop and grow expertise beyond the clinical training and community training by attend conferences at the national or state level or through webinar training. In turn, they can share information with their agencies and the community partners. A team approach to attending the conferences for the first 2 years is recommended.

The goal is to cover the cost of 1-3 individuals from the for the first year to attend a threat assessment conference for the first two years. This excludes the Threat Management Coordinator. It is expected by the end of the fourth year, that Community Partners will fund their own experts to attend these conferences or additional training.

Community Partner Discretionary Funds

In the design and implementation of a community threat assessment program, there may be community partner ideas, training needs, or intervention needs that may have not be anticipated in the development of the grant proposal. Money has been set aside for the community partners to equally share on an annual basis. Any money utilized will have to be presented to the Threat Management Coordinator and MHSA Innovation Coordinator for final approval and must be directly related to threat assessment training or enhancement of the threat assessment process in the community. It is designed to increase alongside the increase of hours of Threat Management Coordinator as there is a decrease in the use of the Clinical and Community Threat Experts.

Anticipated examples include but are not limited to the following:

1) Sending someone to an additional conference or workshop on threat assessment or cover additional costs for an additional professional

2) Seeking legal consultation or opinions regarding their agencies' threat assessment design and procedures

3) Providing additional professional liability coverage to professionals who may provide intervention to or monitoring of students following a threat assessment

4) In Year 2, 3 and 4, provide an incentive stipend to professionals within community partner agencies in allocation of time spent on collecting agency data on threat assessment monitoring and/or providing monitoring of threats within the agency.

NEW ANNUAL PROGRAM BUDGET						
A. EXPENDITURES						
		FY 19-20	**FY 20-21**	**FY 21-22**	**FY 22-23**	**TOTAL**
1.	Personal expenditures (salaries, wages, and benefits)	$15,360	$15,360	$15,360	$15,360	$61,440
2.	Operating expenditures	$6,435	$9,102	9,738	$11,184.4	$36,459.4
3.	Non-recurring expenditures (cost of equipping employees with technology necessary to perform MHSA duties to conduct the Innovative Project)	$5,852.95	$	$	$	$5,852.95
4.	Contracts (Trainers & Consultants)	$62,400 $32,400	$74,880 $24,000	$74,880 $21,000	$93,600 $12,600	$305,760 $90,000
5.	Other expenditures projected to be incurred on items not listed above and provide a justification for the expenditure in the budget narrative.	$3,800 $10,500	$2,800 $12,000	$1,200 $13,500	$16,500	$60,300
	Total Proposed Expenditures	**$136,747.95**	**$138,142**	**$135,678**	**$149,244**	**$559,811**
B. REVENUES						
1.	MHSA Innovation Funds	**$136,747.95**	**$138,142**	**$135,678**	**$149,244**	**$559,811**
2.	Medi-Cal Federal Financial Participation					
3.	1991 Realignment					
4.	Behavioral Health Subaccount					
5	Any other funding (specify)					
	Total Revenues	**$136,747.95**	**$138,142**	**$135,678**	**$149,244**	**$559,811**
C. TOTAL FUNDING REQUESTED		**$136,747.95**	**$138,142**	**$135,678**	**$149,244**	**$559,811**

PERSONNEL COSTS (salaries, wages, benefits)		Ramp up Period FY 19/20	Program Year 1 FY 20/21	Program Year 2 FY 21/22	Program Year 3 And Eval Period FY 22/23	TOTAL
1.	Salaries	$	$	$	$	$
2.	Direct Costs	$	$	$	$	$
3.	Indirect Costs	$	$	$	$	$
4.	Total Personnel Costs	$	$	$	$	$
OPERATING COSTS		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**TOTAL**
5.	Direct Costs	$	$	$	$	$
6.	Indirect Costs	$	$	$	$	$
7.	Total Operating Costs	$	$	$	$	$
NON-RECURRING COSTS (equipment, technology)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**TOTAL**
8.		$0	$0	$0	$0	N/A
9.		$0	$0	$0	$0	N/A
10.	Total Non-recurring costs	$0	$0	$0	$0	N/A
		$0	$0	$0	$0	N/A
CONSULTANT COSTS / CONTRACTS (clinical, training, facilitator, evaluation)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**TOTAL**
11.	Direct Costs	$	$	$	$	$
12.	Indirect Costs	$	$	$	$	$
13.	Total Consultant Costs	$	$	$	$	$
OTHER EXPENDITURES (please explain in budget narrative)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**TOTAL**
14.		$0	$0	$0	$0	N/A
15.		$0	$0	$0	$0	N/A
16.	Total Other Expenditures	$0	$0	$0	$0	N/A
		$0	$0	$0	$0	N/A
BUDGET TOTALS						
Personnel (line 1)		$	$	$	$	$
Direct Costs (add lines 2, 5 and 11 from above)		$	$	$	$	$
Indirect Costs (add lines 3, 6 and 12 from above)		$	$	$	$	$
Non-recurring costs (line 10)		$0	$0	$0	$0	N/A
Other Expenditures (line 16)		$0	$0	$0	$0	N/A
TOTAL INNOVATION BUDGET		**$120,000**	**$167,500**	**$167,500**	**$145,000**	**$600,000**

Appendix 3: HAH Materials

Letter of Support from the Gay And Lesbian Alliance of the Central Coast

June 12, 2019

To: Behavioral Health Board
Re: Holistic Adolescent Health Innovation Project

As organizations that serve LGBTQ+ Youth in San Luis Obispo County, we are delighted to see the proposed Holistic Adolescent Health Innovation Project.

In addition to the California Healthy Kids Survey (CHKS), California Healthcare Foundation, and other statistics quoted in the proposal, the results from the (soon to be released) local QueerCares survey show clearly that LGBTQ+ Youth in San Luis Obispo County are greatly in need of further services aimed at improving mental health and wellbeing. The CHKS survey quoted in the proposal showed 25% of all grade 9 students at SLCUSD had seriously considered suicide in the past year. We now know from the recently released 2017 numbers (attached) that 57.9% of transgender students in San Luis Obispo County have considered it, and 68.7% felt so sad and hopeless they stopped doing usual activities for two weeks or more. The trends show more support is vital.

It is clear that current methods of education and support are not reaching all young people. The innovative idea of a holistic approach to the health curriculum is an excellent one.

Community Action Partnership of San Luis Obispo (CAPSLO) already does an amazing job of health education inclusive of gender and sexual orientation. Their efforts in the County are commendable, sending dynamic instructors into school settings to engage in education and support - not only teaching a class, but also producing quality programs like Teen Monologues.

The comprehensive plan detailed in the proposal gives each student a nuanced education to prepare for a mentally and physically healthy adulthood using mindfulness and coping skills. We think piloting such a project will be an effective way to provide these life lessons.

Our organizations fully endorse this Innovation Project proposal and hope the Behavioral Health Board will vote to implement. We are excited to see the results.

Sincerely,

Gay and Lesbian Alliance of the Central Coast (GALA)
Tranz Central Coast (TCC)
Central Coast Coalition for Inclusive Schools (CCC4iS)
#Out4MentalHealth (a program of the California LGBTQ Health and Human Services Network and NorCal Mental Health America)
Diversity Coalition of San Luis Obispo County (formerly 5 Cities Diversity Coalition)
Your True Gender, The Queer Crowd
5 Cities Hope LGBTQ+ Organization
QueerSLO (www.queerslo.com)
Santa Maria House of Pride and Equality

Letter of Approval from Mental Health Services Oversight & Accountability Commission (MHSOAC)

MHSOAC
Mental Health Services
Oversight & Accountability Commission

STATE OF CALIFORNIA
GAVIN NEWSOM, Governor

KHATERA TAMPLEN
Chair
LYNNE ASHBECK
Vice Chair
TOBY EWING
Executive Director

November 8, 2019

Anne Robin, LMFT
Behavioral Health Administrator
County of San Luis Obispo Behavioral Health Department
2180 Johnson Ave
San Luis Obispo, CA 03401

Dear Ms. Robin,

Congratulations, the Commission has approved the Holistic Adolescent Health Innovation Plan on October 30, 2019 up to the amount of **$660,000** in Innovation funding over four (4) years.

Thank you for your letter dated November 4, 2019, acknowledging the following consideration:

- Individuals with lived experience will continue to be part of the development, implementation, and evaluation of the project and specifically will be included in developing the training program

Please notify Commission staff in writing of the official start date of the Innovation project. Pursuant to the Innovation regulations, the start date is when the County begins implementing the project which is based upon the date funds are first spent or when services are delivered, whichever happens first. (Reference Title 9 CCR, Article 9 §3910.010(a)(1)).

On behalf of the Commission, I would like to thank you for all the work you do in your community.

If you have additional questions or need further assistance, feel free to contact me sharmil.shah@mhsoac.ca.gov or your county liaison Wendy Desormeaux Wendy.Desormeaux@mhsoac.ca.gov.

Sincerely,

Sharmil Shah, Psy.D
Chief-Program Operations

Copy: Nestor Veloz-Passalacqua, M.P.P.-Ethnic Services Manager

Appendix 4: HAH MHSA Application

County Name: San Luis Obispo County

Date Submitted:

Project Title: Holistic Adolescent Health

Total amount requested: $600,000

Duration of project: Four years

Purpose of Document: The purpose of this template is to assist County staff in preparing materials that will introduce the purpose, need, design, implementation plan, evaluation plan, and sustainability plan of an Innovation Project proposal to key stakeholders. *This document is a technical assistance tool that is recommended, not required.*

Innovation Project Defined: As stated in California Code of Regulations, Title 9, Section 3200.184, an Innovation project is defined as a project that "The County designs and implements for a defined time period and evaluates to develop new best practices in mental health services and supports". As such, an Innovation project should provide new knowledge to inform current and future mental health practices and approaches, and not merely replicate the practices/approaches of another community.

Section 1: Innovations Regulations Requirement Categories

CHOOSE A GENERAL REQUIREMENT

An Innovative Project must be defined by one of the following general criteria. The Proposed project:

- **Introduces a new practice or approach to the overall mental health system, including, but not limited to, prevention and early intervention**
- Makes a change to an existing practice in the field of mental health, including but not limited to, application to a different population
- Applies a promising community driven practice or approach that has been successful in a non-mental health context or setting to the mental health system
- Supports participation in a housing program designed to stabilize a person's living situation while also providing supportive service onsite

CHOOSE A PRIMARY PURPOSE

An Innovative Project must have a primary purpose that is developed and evaluated in relation to the chosen general requirement. The proposed project:

- Increases access to mental health services to underserved groups

- **Increases the quality of mental health services, including measured outcomes**
- Promotes interagency and community collaboration related to Mental Health Services or support of outcomes
- Increases access to mental health services, including but not limited to, services provided through permanent supportive housing

Section 2: Project Overview

PRIMARY PROBLEM

What primary problem or challenge are you trying to address? Please provide a brief narrative summary of the challenge or problem that you have identified and why it is important to solve for your community. Describe what led to the development of the idea for your INN project and the reasons that you have prioritized this project over alternative challenges identified in your county.

San Luis Obispo County lacks a coordinated school-based health curriculum to provide high school students with a comprehensive mental, physical, and social health education. Community Action Partnership of San Luis Obispo (CAPSLO), in collaboration with local schools, has determined that the current compartmentalized curricula limit the ability of county youth to attain a whole-person/holistic view of heath or to balance the inter-related aspects of mental, physical and social health engagement processes. With students reporting ever greater struggles to cope with overwhelming stress and anxiety, school officials and staff are asking for resources on how to help teens manage in the current overcharged social environment. This need became a priority as it addresses two areas of concern, one being actively engaging youth ages 13-18 and, secondly it incorporates a comprehensive approach for mental, physical, and social health with mindfulness,

The number of suicide ideation and suicide attempts by US Children doubled between 2008 and 2015 from .66% of children in 2008 to 1.82% in 2015 (Plemmons, et al, 2018). Significant increases were noted in all groups, but the annual increases were higher in adolescents 15 to 17 years of age and adolescents 12 to 14 years. Although increases were noted in both girls and boys, the average annual increase was higher for girls (Plemmons, et al, 2018). One in nine high school girls attempted suicide in 2015 (California Health Care Foundation, p. 2). Young women are also more than twice as likely than young men to report chronic sad or hopeless feelings. (California Health Care Foundation, p. 5). In 2015, 50% of youth who identified as lesbian, gay or bisexual reported that they had seriously considered suicide in the past 12 months. (California Health Care Foundation, p. 6).

According to the Kidsdata.org website, Adverse Childhood Experiences (including child abuse, exposure to violence, family substance abuse, divorce, and poverty) greatly increase the likelihood of major depressive episodes in adolescents and a majority of youth do not receive mental health treatment. Half of all mental illnesses appear by the mid-teens. It is not uncommon for adolescent substance use to begin as a strategy for self-medicating in order to manage early psychiatric symptoms and frequently leading to the co-occurrence of mental illnesses and substance use disorders. (California Health Care Foundation, p. 2).

Locally it has been identified that 7.5% of Central Coast youth have experienced a serious emotional disturbance (California Health Care Foundation, 2018, p. 6). According to the *Community Health Improvement Plan*, of 11th grade students in San Luis Obispo County surveyed in 2015-2016, 33% reported experiencing chronic sadness or hopeless feelings in the past 12 months (2018).
San Luis Obispo County has seen an 11% increase in total cases of substantiated child abuse from 2010 to 2015 (from 9.8 to 11.3 per 1,000). In December 2016, 378 children were in foster care in San Luis Obispo County, an increase from 17% since 2010 (Diringer, 2018, p. 5-7). On average a child in foster care is 2x more likely to develop PTSD that a war veteran (Family Care Network, 2019.) Lesbian, gay bisexual, and transgender students report much higher rates of abuse and feeling unsafe at school. (California Health Care Foundation, p. 6). The County's rate of forcible rape is much higher than the State rate and the county suicide rate is consistently above the State rate – 50% higher (Diringer, 2018, p. 7). According to the *California Healthy Kids Survey*, 33% of 9th Grade students in the Lucia Mar Unified School District (LMUSD) and 31% of those in the San Luis Coastal Unified School District (SLCUSD) had experienced chronic sadness or hopelessness. The numbers for non-traditional students rose to 44% and 53% respectively. Nineteen percent of students in Grade 9 in the LMUSD and 15% of those in SLCUSD had considered suicide, and those rates again increased to 22% and 38% respectively for those in a non-traditional school setting (CalSCHLS, 2018).

In discussing the state of school-based health services, the *2018 California Children's Report Card* reports that although some efforts are being made to "improve school climate and teacher training to support student wellness, and increased screening and referral for mental health and trauma services,… more must be done to develop a [coordinated system of care] that meets kids' needs." San Luis Obispo County has designated the improvement of the social and emotional support network for teens in SLO County as one of two Social and Emotional Wellness Priorities (Community Health Improvement, 2018). The County believes teaching mental health coping skills to teens is a vital determinant of the overall health of youth and an important component to early intervention efforts.

PROPOSED PROJECT

Describe the INN Project you are proposing. Include sufficient details that ensures the identified problem and potential solutions are clear. In this section, you may wish to identify how you plan to implement the project, the relevant participants/roles within the project, what participants will typically experience, and any other key activities associated with development and implementation.

A) Provide a brief narrative overview description of the proposed project.

The Innovation Project seeks actively engages youth ages 13-18 in the co-creation of a new health curriculum delivery model. Second, with the addition of mindfulness training, the Project implements a comprehensive approach to mental, physical, and social health. Adding a mindfulness skill-building component to the existing high school health curriculum would enhance the ability of adolescents to make positive life choices related to their own health and well-being. There are no studies regarding a supportive model that integrates mindfulness into an existing health curriculum covering physical, sexual and social health for teens ages 13-18 in a school-based environment.

The Innovation Project is part of an ongoing collaboration between the Community Action Partnership of San Luis Obispo (CAPSLO) and local high schools. CAPSLO is a 501(c)(3) non-profit community-based organization with a 40-year history of providing sexual health education in local high schools and

middle schools. Since 2010, CAPSLO has expanded the availability of comprehensive, evidence-based, sexual health curriculum to high-need schools on the Central Coast of California. CAPSLO also partners with Community Health Centers (CHC) to provide local high schools with school-based obesity prevention programs that focus on students' nutrition and fitness practices.

CAPSLO works closely with school administrators and faculty to identify student needs, engage students, and create programs that encourage student buy-in. More importantly, the project encourages teens to and take ownership of and proactively manage their own health and well-being. The Innovation Project develops and employs a new curriculum which focuses on the needs of and utilizes feedback from San Luis Obispo County adolescents. It also incorporates a new health education delivery model which integrates training on mindfulness skills into the existing health curriculum provided at high schools. The County posits that better physical and social-emotional health outcomes can be achieved through the implementation of this new curriculum and delivery model, that includes 1) 15-sessions on mindfulness skill and knowledge learning, and 2) one-on-one coaching and follow up with youth. Because physical health and socio-emotional wellness are inextricably tied together, the new curriculum and delivery method will help youth gain perspective on how all behaviors are interconnected and better understand how to cope effectively with stress, anxiety, and other symptoms.

Proposed Sites

The new health education model will be introduced and implemented at two school sites. The selected schools, Morro Bay High School in the San Luis Coastal Unified School District and Lopez Continuation High School in the Lucia Mar Unified School District, have requested support as part of the schools' ongoing health education classes offered each semester. This new model uses an existing health education curriculum and adapts it, while retaining the evidence-based components of the existing curriculum, to include the new mindfulness elements and additional health information in order to better meet the needs of local teens.

Key Components

- Blended health education model that includes 15 sessions of mental health, physical health, and sexual health education to students through their regular health classes.
- Health Educator one-on-one health coaching program that provides individual mental, physical and sexual health education support for interested students.

The in-class component builds on and expands the current curriculum. The Innovation Project will include mental health, physical health and sexual health education units. The mental health units will include Mindfulness Awareness Practices (MAPs) such as the STOP process (Stop, Take a Breath, Observe, and Proceed), body awareness scans, breathing, meditation and feelings identification. The physical health units will include the U.S.D.A.'s MyPlate nutrition education, training on how to read nutrition labels, meal planning, setting SMART fitness and nutrition goals (Specific, Measurable, Attainable, Realistic, Time-bound), and fitness coaching (2018). Sexual health units will focus on healthy relationships, pregnancy and STI prevention, and birth control methods.

Health coaching involves students meeting one-on-one with a Health Educator up to two times per month for approximately 30-minutes per session throughout the school year. The discussions are student-driven and focus on setting and meeting health goals, further developing mindfulness skills,

and additional education on specific topics of personal interest to the student. Each session will include mindfulness training.

The proposed and appointed new curricula will be conducted by the Health Educators. The Health Educators receive approximately 200 hours of extensive training covering topics related to all aspects of the blended health education model to be delivered through the Innovation Project. Trainings prepare staff to provide a professional, medically-accurate, evidence-based education which is culturally-inclusive, developmentally-appropriate, and trauma-informed. The curricula will also cover social and emotional health, in addition to mental, physical, sexual health. Staff will be trained in the following areas:

Mental Health:

- Motivational Interviewing;
- Mindfulness through an evidence-based program such as Trails to Wellness;
- Cognitive Behavioral Therapy approaches.

Physical Health and Nutrition:

- The Dietary Guidelines for Americans 2015-2020;
- USDA MyPlate nutrition guide;
- Diabetes education;
- National Academy of Sports Medicine (NASM);
- Health at Every Size paradigm.

Sexual Health (as mandated by the State Education Code), including social and emotional health:

- Positive Prevention PLUS sexual health education curriculum as mandated by the State;
- Foundations Core Skills Training;
- Trauma Informed Classroom Management/Trauma Stewardship;
- Positive Youth Development;
- Domestic Violence Disclosure and Mandated Reporter;
- LGBT Ally/Youth Engagement, Inclusive Schools Network, Teaching Transgender Toolkit.

After completing the training sessions, Health Educators participate in an evaluation process before presenting to students in the classroom and engaging students through one-on-one health coaching. This process includes observing trainers, presenting mock teaching sessions, and co-teaching. Through the training and evaluation periods, Health Educators receive on-going support and feedback from supervisors, trainers, and peers.

Through both the high school health classes and on-site one-on-one health coaching and nutrition consulting by trained Health Educators, Innovation Project Staff will provide participating teens with mindfulness tools to help them achieve stress reduction, reduce emotional reactivity, and improve health behaviors. Emphasis will be placed on offering regular opportunities to practice the new skills. The specific elements selected for each module will be designed to address the needs of emerging adults who often feel they have few emotional resources from which to draw.

The Innovation Project will develop the mindfulness training from various evidence-based programs intended to help students calm their minds to manage stress and lead healthier lives. The emphasis will be on teaching practical skills students can use to manage stress by focusing their minds and gaining perspective around the issues and challenges they may be facing. The program will train

participants in mind-body skills such as abdominal breathing and guided imagery, which have been shown to increase both self-care and the motivation to continue practicing stress reduction. Mindfulness training emphasizes the cultivation of positive emotions such as gratitude and compassion. Behavioral health activity outcomes to be tracked include self-compassion, awareness of intentional behavioral activities, perceived stress levels, the consumption of healthy foods/drinks, increased body awareness, the amount and quality of sleep, and emotional comfort levels within relationships. Staff will employ motivational interviewing technique to elicit student-driven behavior change. Our approach also utilizes the tenants of cognitive behavioral therapy to enable students to act intentionally rather than reacting reflexively in both stressful and everyday situations.

By using a combination of in-class instruction, one-on-one health coaching, and mindfulness learning strategies, the Innovation Project will be evaluated in the following ways: Students who participate in the Innovation Project will take a pre-test to assess student knowledge, behaviors and attitudes prior to any instruction or coaching through the project. Post-tests will be conducted at the end of coursework and again following the coaching period to determine the effects of mindfulness on health behaviors such as stress reduction, activity level, consumption of sugary beverages, consumption of fruits and vegetables, self-regulation in sexual settings, and self-awareness and improvement within relationships. The data will be both quantitative and qualitative. A satisfaction survey will provide important program feedback from students to guide continuous quality improvement.

B) Identify which of the three project general requirements specified above [per CCR, Title 9, Sect. 3910(a)] the project will implement.

Introduces a new practice or approach to the overall mental health system, including but not limited to, prevention and early intervention.

C) Briefly explain how you have determined that your selected approach is appropriate. For example, if you intend to apply an approach from outside the mental health field, briefly describe how the practice has been historically applied.

The approach of the Project utilizes staff to create a more comprehensive mental, physical and sexual health program that is student-driven and allows health educators to respond to requests for information as well as identify the areas of greatest need and trends in student health needs. Teen suicides rates have doubled in recent years; college mental health referrals requested by students have strained many university health centers; school counselors, teachers and staff are overwhelmed. (Plemmons, et. al, 2018) (Center for Collegiate Mental Health Annual Report, 2017) Though many studies have looked at potential solutions, incorporating mindfulness awareness practices into existing health curriculum may promise the best results. All known studies have tracked mindfulness-based stress reduction (MBSR) programs on adults and youth, the academic benefits to students, or students with diagnosed issues such as attention deficit disorders. However, this project will focus on tracking physical health outcomes through increases in the intentional behaviors resulting from MAPs.

D) Estimate the number of individuals expected to be served annually and how you arrived at this number.

Approximately 120 participants will be served in classrooms per academic year across the two sites, with an expected total of 360 participants served over the three academic years of the INNovation Project testing period. Health Educators will partner with staff at Morro Bay High School and Lopez Continuation High School to offer the blended Innovation Project model. Each academic year, approximately 120 students will be reached via classroom presentations, with approximately 40 of those students participating in one-on-one- health coaching.

E) Describe the population to be served, including relevant demographic information (age, gender identity, race, ethnicity, sexual orientation, and/or language used to communicate)

The participants will be youth ages 13-18 from Morro Bay High School and Lopez Continuation High independent of age, gender, sexual orientation, race, ethnicity, language or disability. Efforts will be made to provide culturally competent services to all participants.

RESEARCH ON INN COMPONENT

A) What are you proposing that distinguishes your project from similar projects that other counties and/or providers have already tested or implemented?

The Innovation Project incorporates mindfulness and coping skills training into an existing high school health curriculum and will introduce this model to two school sites not currently being served by CAPSLO staff. Through trained Health Educators, students' intentional behavioral health outcomes will be tracked. These include perceived levels of stress and self-compassion, increased body awareness, activity level, consumption of sugary beverages, consumption of fruits and vegetables, comfort level within the context of personal relationships, and intended sexual health decisions are all tracked. Although many studies reported on the impact of mindfulness training in school settings, none were added to an existing high school health curriculum using a blend of comprehensive physical health, nutrition and fitness, sexual health, and mindfulness into a cohesive holistic health program. One study looked at the impact on resting and ambulatory blood pressure and heart rate in youth, but not on additional youth health outcomes (Barnes, 2004). Health is often taught in a compartmentalized fashion. This proposal seeks to test a model for comprehensive health education that includes mental, physical and sexual health components, and tests the link between mindfulness practices and healthy behavior decisions. In addition, this project seeks to identify whether the utilization of one-on-one coaching of students produces a more profound change in knowledge, skills, and health practices than simple classroom instruction.

B) Describe the efforts made to investigate existing models or approaches close to what you're proposing. Have you identified gaps in the literature or existing practice that your project would seek to address? Please provide citations and links to where you have gathered this information.

Multiple searches were conducted on various research, scientific and government websites to determine where gaps in behavioral science research exist.

LEARNING GOALS/PROJECT AIMS

The broad objective of the Innovative Component of the MHSA is to incentivize learning that contributes to the expansion of effective practices in the mental health system. Describe your learning goals/specific aims and how you hope to contribute to the expansion of effective practices.

A) What is it that you want to learn or better understand over the course of the INN Project and why have you prioritized these goals?

The Innovation project's goals are as follows:

5. The County and its stakeholders hope to learn if the model effectively increases the ability of teens ages 13-18 to cope with stress and anxiety.

6. The County and its stakeholders hope to learn if incorporating the teaching of mindfulness practices in conjunction with other health-focused curriculum increase teens' ability to make healthy decisions regarding their mental, physical, and sexual well-being.

7. The County and its stakeholders hope to learn if inclusion of one-on-one coaching increases the likelihood that students will practice what they learned in health classes.

8. The County and its stakeholders hope to learn better methods to increase prevention and early detection of mental health-related issues.

B) How do your learning goals relate to the key elements/approaches that are new, changed or adapted in your project?

The overarching goal is to assess whether incorporating the key element of mindfulness training into a high school health curriculum, thereby creating a balanced approach to wellness education that addresses, mental health, physical health, and sexual health, will positively impact health behaviors and outcomes. By testing a new health curriculum delivery model that includes these components, the Innovation Project hopes to determine whether mental, physical and sexual behaviors changes occur and if so, whether they positively impact a young person's measurable health outcomes.

EVALUATION OR LEARNING PLAN

For each of your learning goals or specific aims, describe the approach you will take to determine whether the goal or objective was met. Specifically, please identify how each goal will be measured and the proposed data you intend on using.

Through collaboration with an external evaluator, the Innovation Project will identify and develop questions for pre- and post-assessment surveys to measure goals and objectives. These will include whether mindfulness training is an effective curriculum component for enhancing the current health

education model to improve health behaviors and outcomes, while reducing student feelings of stress, anxiety, and/or depression.

The Innovation project's aims/outcomes are the following:

9. Increase the mood stability and overall feelings of well-being of the participating students;
    a) Metrics include pre- and post-surveys of participating students
    b) Metrics include data from motivational interviews
10. Increase the overall student level of physical fitness activity and nutrition knowledge;
    a) Metrics include pre- and post-surveys of participating students
    b) Metrics include data from motivational interviewing
11. Increase the student's ability to identify and cope with feelings, especially negative emotions such as depression and/or anxiety;
    a) Metrics include pre- and post-surveys of participating students
    b) Metrics include data from motivational interviews

- Increase student intentionality regarding behaviors related to health
    a) Metrics include pre- and post-surveys of participating students
    b) Metrics include data from motivational interviews
- Determine if one-on-one coaching improves the likelihood that students will utilize the knowledge and tools taught
    a) Metrics include pre- and post-surveys of participating students
    b) Metrics include data from motivational interviews

12. Establish a referral process for youth who may need additional assistance
    a) Metrics include pre- and post-surveys of participating students
    b) Metrics include data from motivational interviews
13. Increase overall student level of sexual health* knowledge and awareness as it relates to; identifying signs of healthy and unhealthy relationships, identifying how to respond to pressures from peers, media, and society to engage in high risk behaviors, identifying abstinence as the only 100% safe method to avoid an unplanned pregnancy, sexually transmitted infections (STIs), and HIV, and identifying community resources for STI/HIV testing, contraceptive methods, and other sexual and reproductive health services

a) Metrics include pre- and post-assessments of participating students

*Participant learning outcomes, as they relate to sexual health, will adhere to the Evidence Based Program (EBP), Positive Prevention PLUS, which complies with the California Education Code 51935.

Testing and Evaluation of Outcomes

- CAPSLO staff working on the Innovation Project will collaborate with diverse stakeholders and an outside evaluation agency to use culturally-appropriate data collection instruments and metrics to measure perceived stress levels and behavioral intent as they relate to stress alleviation, healthy decision-making, nutrition, physical activity, and relational communication.
- Pre-Instruction surveys will be administered at the beginning of the in-class curriculum.
- Prior to individual coaching, health coaches will evaluate student physical health as well as knowledge and behaviors through free response questions and pre-instruction surveys.
- Physical health outcomes measured will include body mass index and cardiovascular endurance. Other assessment will include student knowledge of food labels, My Plate, sleep, and healthy lifestyle recommendations.
- Post-instruction surveys will be administered at the conclusion of classroom curriculum.
- Health coaching surveys will assess changes to students' behavior by tracking their patterns of sleep, food/drink intake, attainment of fitness goals, and level physical activity. Innovation Project participants will have the opportunity to share their lived experiences in the form of a retrospective focus group. The narrative data will be coded and transcribed by the evaluation agency.

Section 3: Additional Information for Regulatory Requirements

CONTRACTING

If you expect to contract out the INN project and/or project evaluation, what project resources will be applied to managing the County's relationship to the contractor(s)? How will the County ensure quality as well as regulatory compliance in these contracted relationships?

The County plans to select a contract provider who will best execute the project. The County has outstanding contractual partnerships across the community mental health system, as well as strong relational partnerships with many community schools, colleges, health providers, and law enforcement agencies. The Behavioral Health Department, including the MHSA Administrative Team, is well-equipped to conduct a fair and successful procurement process (in partnership with County Purchasing) and expedite a contract to be sure Innovation timelines presented herein are met.

The County Innovation Component Coordinator, Nestor Veloz-Passalacqua (Administrative Services Officer II), is the community liaison for all Innovation (and PEI) projects and evaluation. Nestor coordinates the stakeholder planning process and will be the one to develop any RFP to select providers. The MHSA Administrative Team also includes Frank Warren (Division Manager), the County MHSA Coordinator, who manages all aspects of MHSA, including contracts and plan monitoring. Briana Hansen, Accountant III, is the fiscal lead and works with each provider to develop accurate budgeting and spending plans. Kristin Ventresca, the CSS Coordinator (Administrative Services Officer II), also provides contract management and oversight. Nestor uses California Polytechnic State University statistics and public policy students that assist in data collection, technical assistance for providers, and reporting as part of paid internship positions.

All Innovation Project providers will meet regularly with Nestor and the team before and during the start-up phase to finalize plans, conduct data collection tests, and develop tools. Some plans may need to be adjusted (based on hiring, procurement of materials, etc.) and Nestor will work with each contractor to provide support and guidance to keep the projects on time. After the launch of each project, Nestor will work with the contractors to provide quarterly reports and data collection. The MHSA Administrative Team will conduct spot checks, review project materials, and review quarterly reports to ensure quality and regulatory compliance.

Additionally, the County will establish a contract with an Evaluator to manage the analysis of data, as well as provide technical assistance to the projects to be sure tools are developed which accurately measure the results of each objective. This Evaluator will provide regular reports to the MHSA Administrative Team and MHSA Advisory Committee (stakeholder group), as well as the final report which will be provided to the MHSOAC.

COMMUNITY PROGRAM PLANNING

Please describe the County's Community Program Planning process for the Innovative Project, encompassing inclusion of stakeholders, representatives of unserved or under 5 served populations, and individuals who reflect the cultural, ethnic and racial diversity of the County's community.

A new round of Innovation Projects was launched in October 2018. The first Innovation Stakeholder meeting took place in October 11, 2018 at which new and current Innovation Stakeholders were present to review the innovation guidelines and begin a larger conversation and collaboration process for research and testing new meaningful ideas in our community. Community members ranging from psychologists, to educators, and think tank members were present, as well as mental health providers and partners. The County made available information containing steps to successfully submit an innovation idea, along with providing technical assistance in developing the narrative piece of the proposal. One of the most enthusiastic and eager organizations was CAPSLO. At an initial meeting they presented the first iteration of their idea to integrate and develop a new mental health curriculum that included mindfulness, physical, and social-emotional development. This project is part of larger collaboration between CAPSLO and local high schools, focusing on the development of a new curriculum and delivery model. The project continued to be refined as County staff, CAPSLO and school representatives were involved. The project's curriculum and delivery method would allow youth to experience a cohesive and comprehensive education focused on mindfulness, physical fitness and nutrition, and sexual health as part of a holistic high school health program. The original project design is the result of community engagement between CAPSLO, local school districts, and youth. Additionally, the Behavioral Health Department has provided technical assistance support to refine and coordinate efforts to make the proposal a priority in reference to what

the community needs are. The project design utilized feedback from schools identifying the need for additional support and a comprehensive curriculum that addresses the needs in teen developmental areas, including the need to build a curriculum and delivery model that leads to youth being connected to mental health services and a recovery process when needed. The County continues to provide ongoing technical support, and procedural information to the development and completion of this proposal. The continued collaboration between stakeholders, community members, and school staff affirms the community-wide acknowledgment of the dire need for a cohesive and comprehensive curriculum so that county youth are provided with an opportunity to feel engaged and to help them achieve success and mental health wellbeing.

The Innovation Project team has solidified their efforts with CAPSLO, schools, and stakeholders to emphasize and coordinate proper coordination and implementation of the proposal. The staff and appropriate partners, such as CAPSLO, school representatives, and stakeholders will continue to meet regularly during the project development, implementation, and evaluation to identify and address challenges, and to coordinate proper engagement for the intervention being tested. Currently the County Innovation Coordinator has received feedback from the Mental Health Services Oversight and Accountability Commission (MHSOAC) to ensure Innovation Project guidelines and regulations are met. The feedback and edits have been implemented into the proposal. Part of the efforts for a successful proposal includes the continued collaboration and coordination with the County and community-based organizations to ensure the inclusion of a wide representation of staff, and to ensure planning efforts reflect the community collaboration and the impact on the youth population.

MHSA GENERAL STANDARDS

Using specific examples, briefly describe how your INN Project reflects, and is consistent with, all potentially applicable MHSA General Standards listed below as set forth in Title 9 California Code of Regulations, Section 3320 (Please refer to the MHSOAC Innovation Review Tool for definitions of and references for each of the General Standards.) If one or more general standards could not be applied to your INN Project, please explain why.

A) Community Collaboration

The project is designed to facilitate a strong collaboration that includes youth, community-based organizations, School Districts, County Behavioral Health Department, and family and community members. The Project fosters and maintains community collaboration through a process of consistent stakeholder advisory group interaction, and by representing diverse racial/ethnic, cultural, and linguistic communities. The Project works with family advocates, mental health providers, school district staff, families, parents/caregivers, and other professionals to enhance and develop a cohesive and comprehensive classroom curriculum.

B) Cultural Competency

The Project is designed to impact diverse youth from across the County. The project employs culturally and linguistically appropriate staff who will engage clients through service delivery that fosters equal access to services without disparities. Additionally, through the project design, the stakeholder advisory group incorporates culturally and linguistically appropriate guidance in the administration, implementation, delivery, and evaluation processes. Cultural competency will be achieved by providing participants with the opportunity to participate in the project in which all services will be

delivered in the participant's primary language. Services will engage and retain diverse individuals through recruitment by a trusted source. The stakeholder advisory group will monitor the project for disparities in services using process data and community data provided by the project data analyst.

C) Client-Driven

The project is designed to engage staff that work primarily with youth, who are ultimately the population that will be impacted by the Innovation project. Individual student's experiences, and individualized information will provide guidance and lead to a better participant understanding of the curriculum, the best practices and continual fine-tuning of the approach necessary to identify and engage with those youth who may be benefit from a cohesive and comprehensive course.

D) Family-Driven

The project is designed to engage youth and their direct family support network as the primary agents of information. Their involvement will shape program decision-making, and which elements of the curriculum and approach are essential to assist youth in developing a mindful, healthy, and informed lifestyle.

E) Wellness, Recovery, and Resilience-Focused

The Project services maintain the philosophy, principles, and practices of the Recovery Vision. Prevention and Early Intervention pieces often prevents or mitigates behavioral and social problems; therefore, early referrals and connection to mental health resources and supports are a focus of the project. Youth and parental empowerment and social connections are critical to the well-being of the students. Youth are also supported by offering community information on accessing services.

F) Integrated Service Experience for Clients and Families

The Project involves an integrated community approach and resource knowledge experience. Project partners and staff work on providing seamless coordination between County agencies and community providers as a referral resource available to youth in order to create a larger system of mental health care coordination.

CULTURAL COMPETENCE AND STAKEHOLDER INVOLVEMENT IN EVALUATION

Explain how you plan to ensure that the Project evaluation is culturally competent and includes meaningful stakeholder participation.

Each student participant will be given in-class time to complete pre- and post-assessments to determine their level of knowledge related to health information, attitudes, and behaviors. In addition, students will be asked to complete a satisfaction survey, designed to gather feedback regarding their perceptions of the quality and usefulness of the information received, their reflections on staff preparedness and sensitivity to the needs of students, their recommendations for changes or improvements, and their overall satisfaction with the program.

An advisory group of stakeholders at each school will gather the perspectives and recommendations for continuous quality improvement. The advisory groups will include a variety of school personnel, parents,

students, and community members with backgrounds in health/behavioral health, fitness, or mindfulness. There will be regular updates on the program, results, feedback, and support. Research questions will also be shared with advisory groups to ensure that questions are age-appropriate and sensitive to the cultural backgrounds of students.

INNOVATION PROJECT SUSTAINABILITY AND CONTINUITY OF CARE

Briefly describe how the County will decide whether it will continue with the INN project in its entirety, or keep particular elements of the INN project without utilizing INN Funds following project completion. Will individuals with serious mental illness receive services from the proposed project? If yes, describe how you plan to protect and provide continuity of care for these individuals upon project completion.

In addition to the staff training and administrative costs of implementing the program at two sites, there will be project costs associated with the staffing, design of assessments, data collection, reporting and evaluation. After the initial training and joint implementation costs are incurred, staff hopes grants and partnerships with local government, individual schools, community groups, and health agencies (such as CHC) will protect the continuity of care for students if the model proves to be effective. Also, any savings to the county derived from the process of teaching students to better cope with stress and anxiety can be expanded by implementing the model at other local schools. This could prevent the development of more debilitating mental health problems, which would add to the drain on the county's Mental Health Agency. Early intervention through the process of educating and coaching students, will potentially lessen the number of teens and young adults needing additional, expensive mental health services. Any teens needing additional health services will be referred to medical professionals, school counselors or mental health service agencies both during and after the project period.

COMMUNICATION AND DISSEMINATION PLAN

Describe how you plan to communicate results, newly demonstrated successful practices, and lessons learned from your INN Project.

A) How do you plan to disseminate information to stakeholders within your county and (if applicable) to other counties? How will program participants or other stakeholders be involved in communication efforts?

The Innovation Project will produce quarterly reports with detailed information on the program accomplishments and challenges. Online quarterly newsletters will also become available and will be posted on social platforms such as Instagram, and Facebook pages. Content will be developed in concert with student participants and school personnel to communicate how the project is evolving and what is being learned. We plan to include testimonials from students, parents, and school staff. At the end of the four-year grant, there will be a comprehensive and detailed report available to the County and the stakeholders.

B) KEYWORDS for search: Please list up to 5 keywords or phrases for this project that someone interested in your project might use to find it in a search.

Teen Health and Wellness
School-based Wellness Training

Holistic Adolescent Health
Comprehensive Teen Health Education

TIMELINE

A) Specify the expected start date and end date of your INN Project

- Start: October 1, 2019 End: September 30, 2023

B) Specify the total time frame (duration) of the INN Project

- Four years

C) Include a project timeline that specifies key activities, milestones, and deliverables—by quarter.

Ramp up/Planning: October - December 2019

- Develop and finalize the curriculum
- Plan and solidify implementation logistics with school sites
- Hire and train Health Educators
- Contract with research partner
- Develop data collection tools
- Coordinate the health curriculum delivery schedule with health teachers

Implementation Cohort 1: January - June 2020

- Provide 15 in-classroom health modules to approximately 60 students, ages 13-18 years, across two high school sites. Administer pre- and post- instruction assessments. Recruit student participants for one-on-one health coaching sessions.
- Provide health coaching to approximately one-third (20) of the students from the in-classroom modules who opt to receive a series of six one-on-one health coaching sessions.
- Administer pre- and post-coaching assessment to student participants.
- Communicate with Research Partner and receive evaluation/assessment results for Cohort 1.

Implementation Cohort 2: August - December 2020

- Provide 15 in-classroom health modules to approximately 60 students, ages 13-18 years, across two high school sites. Administer pre- and post- instruction assessments. Recruit student participants for one-on-one health coaching sessions.
- Provide health coaching to approximately one-third (20) of the students from the in-classroom modules who opt to receive a series of six one-on-one health coaching sessions.
- Administer pre- and post-coaching assessment to student participants.
- Communicate with Research Partner and receive evaluation/assessment results for Cohort 2.

Implementation Cohort 3: January - June 2021

- Provide 15 in-classroom health modules to approximately 60 students, ages 13-18 years, across two high school sites. Administer pre- and post- instruction assessments. Recruit student participants for one-on-one health coaching sessions.
- Provide health coaching to approximately one-third (20) of the students from the in-classroom modules who opt to receive a series of six one-on-one health coaching sessions.
- Administer pre- and post-coaching assessment to student participants.
- Communicate with Research Partner and receive evaluation/assessment results for Cohort 3.

Implementation Cohort 4: August - December 2021

- Provide 15 in-classroom health modules to approximately 60 students, ages 13-18 years, across two high school sites. Administer pre- and post- instruction assessments. Recruit student participants for one-on-one health coaching sessions.
- Provide health coaching to approximately one-third (20) of the students from the in-classroom modules who opt to receive a series of six one-on-one health coaching sessions.
- Administer pre- and post-coaching assessment to student participants.
- Communicate with Research Partner and receive evaluation/assessment results for Cohort 4.

Implementation Cohort 5: January - June 2022

- Provide 15 in-classroom health modules to approximately 60 students, ages 13-18 years, across two high school sites. Administer pre- and post- instruction assessments. Recruit student participants for one-on-one health coaching sessions.
- Provide health coaching to approximately one-third (20) of the students from the in-classroom modules who opt to receive a series of 6 one-on-one health coaching sessions.
- Administer pre- and post-coaching assessment to student participants.

- Communicate with Research Partner and receive evaluation/assessment results for Cohort 5.

Implementation Cohort 6: August - December 2022

- Provide 15 in-classroom health modules to approximately 60 students, ages 13-18 years, across two high school sites. Administer pre- and post- instruction assessments. Recruit student participants for one-on-one health coaching sessions.
- Provide health coaching to approximately one-third (20) of the students from the in-classroom modules who opt to receive a series of six one-on-one health coaching sessions.
- Administer pre- and post-coaching assessment to student participants.
- Communicate with Research Partner and receive evaluation/assessment results for Cohort 6.
- Begin developing final evaluating program results.
- Explore possible community partnerships and leverage funding opportunities.
- Explore possible opportunities to publicize and disseminate results.

Ramp down/Evaluation: January - July 2023

- Collaborate with the Research Partner to publish results of the study.
- Secure funding needed for replication if this holistic teen health education model proves successful.

Section 4: INN Project Budget and Source of Expenditures

INN PROJECT BUDGET AND SOURCE OF EXPENDITURES

The next three sections identify how the MHSA funds are being utilized:

A) BUDGET NARRATIVE (Specifics about how money is being spent for the development of this project)

B) BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY (Identification of expenses of the project by funding category and fiscal year)

C) BUDGET CONTEXT (are MHSA funds being leveraged with other funding sources?)

BUDGET NARRATIVE

Provide a brief budget narrative to explain how the total budget is appropriate for the described INN project. The goal of the narrative should be to provide the interested reader with both an overview of the total project and enough detail to understand the proposed project structure. Ideally, the narrative

would include an explanation of amounts budgeted to ensure/support stakeholder involvement (For example, "$5000 for annual involvement stipends for stakeholder representatives, for 3 years: Total $15,000") and identify the key personnel and contracted roles and responsibilities that will be involved in the project. Please include a discussion of administration expenses (direct and indirect) and evaluation expenses associated with this project. Please consider amounts associated with developing, refining, piloting and evaluating the proposed project and the dissemination of the Innovative project results.

The four-year budget is designed to withstand increases in personnel and operating costs such as rents. The program is not leveraging other funds at this time. Salaries for the four years include a 2% COLA increase and any anticipated promotions. Fringe benefit costs includes the following: FICA, SUI, Health Insurance, Disability Insurance, Workers Compensation, and Retirement. We anticipate that most fringe benefit items will increase and are calculated with per annual increases.

Personnel Expenditures

Health Educators @ 50% FTE (2 Employees): Each Educator will deliver curriculum content at the two schools and collect pre/post-test and satisfaction survey data; assist in the refinement of the instruction model.

Sexual Health Education Coordinator @ 9% (1 Employee): The Coordinator will manage curriculum development and implementation with the two school sites; assist in the development of data collection tools; communicate regularly with the Wellness Project Supervisor and Youth Programs Director regarding the status of work at each of the two sites.

Wellness Project Supervisor @ 10% (1 Employee): The Supervisor will monitor staff time, program implementation objectives, and development of reports; coordinate with San Luis Obispo County Behavioral Health representatives and Philliber Research staff in developing planning adjustments and data collection procedures.

Youth Programs Administrative Assistant @ 9% (1 Employee): The Administrative Assistant will help with collecting and mailing data to Philliber Research, report preparation, scheduling planning meetings, preparing invoices, vouchers, purchases, and other assistance as needed

Youth Programs Director @ 9% (1 Employee): The Youth Programs Director will facilitate contracts, budgeting, and reporting for the project; work with Wellness Project Supervisor, San Luis Obispo County Behavior Health, and Philiber Research on development of performance measures: ensure that stakeholders are included in the planning and feedback processes

Division Director @ 2% (1 Employee): The Director will monitor and approve written agreements and budgets for the Innovation Project.

Operating Expenditures

Program Supplies: Supplies required for the operation of the program, duplication, materials, print cartridges, signs, evaluation tools and rosters.

Local Mileage: Reimburse staff for the use of personal vehicles for program business.

Vehicle Maintenance: Ongoing upkeep of organization vehicles used by staff for program business, such as preparing events. This includes fuel, maintenance and DMV fees.

Rent: Includes the space used by staff at the San Luis Obispo Office.

Utilities: Includes gas, water, trash, and electricity for program office

Janitorial: Services for program office.

Equipment Repair and Maintenance: Includes the upkeep and maintenance of office equipment, including copiers, computers, and printers.

Liability Insurance: The share of the cost of liability insurance for the program office, program employees, and vehicles.

Printing: Includes staff business cards, program brochures, referral cards, training materials for health clinics, social workers and parent education workshops, and promotional flyers for teen events and school administrators and students.

Telephone: Phone service for program staff.

Indirect: The agency indirect rate for expenses is 8%, which include administrative costs.

Contracts

Evaluation Consultant: Design of evaluation tools to measure achievement of E-B curriculum objectives and outcomes, and efficacy of CAG community mobilization and program dissemination activities; measure program outcomes to determine the extent to which they are the result of the program; design a comprehensive community needs assessment; prepare an implementation study report; and prepare a final outcome evaluation report that summarizes results of the study.

PERSONNEL COSTS (salaries, wages, benefits)		Ramp up Period FY 19/20	Program Year 1 FY 20/21	Program Year 2 FY 21/22	Program Year 3 And Eval Period FY 22/23	TOTAL
1.	Salaries	$52,344	$76,910	$77,502	$59,545	$266,301
2.	Direct Costs	$18,241	$28,828	$28,786	$21,834	$97,689
3.	Indirect Costs	$5,647	$8,459	$8,503	$6,510	$29,119
4.	Total Personnel Costs	$76,232	$114,197	$114,791	$87,889	$393,109
OPERATING COSTS		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**TOTAL**
5.	Direct Costs	$19,596	$34,750	$34,200	$31,950	$120,496
6.	Indirect Costs	$1,568	$2,780	$2,736	$2,556	$9,640
7.	Total Operating Costs	$21,164	$37,530	$36,936	$34,506	$130,136
NON-RECURRING COSTS (equipment, technology)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**TOTAL**
8.		$0	$0	$0	$0	N/A
9.		$0	$0	$0	$0	N/A
10.	Total Non-recurring costs	$0	$0	$0	$0	N/A
		$0	$0	$0	$0	N/A
CONSULTANT COSTS / CONTRACTS (clinical, training, facilitator, evaluation)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**TOTAL**
11.	Direct Costs	$20,930	$14,605	$14,605	$20,930	$71,070
12.	Indirect Costs	$1,674	$1,168	$1,168	$1,675	$5,685
13.	Total Consultant Costs	$22,604	$15,773	$15,773	$22,605	$76,755
OTHER EXPENDITURES (please explain in budget narrative)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**TOTAL**
14.		$0	$0	$0	$0	N/A
15.		$0	$0	$0	$0	N/A
16.	Total Other Expenditures	$0	$0	$0	$0	N/A
		$0	$0	$0	$0	N/A
BUDGET TOTALS						
Personnel (line 1)		$52,344	$76,910	$77,502	$59,545	$266,301
Direct Costs (add lines 2, 5 and 11 from above)		$58,767	$78,183	$77,591	$74,714	$555,556
Indirect Costs (add lines 3, 6 and 12 from above)		$8,889	$12,407	$12,407	$10,741	$44,444
Non-recurring costs (line 10)		$0	$0	$0	$0	N/A
Other Expenditures (line 16)		$0	$0	$0	$0	N/A
TOTAL INNOVATION BUDGET		**$120,000**	**$167,500**	**$167,500**	**$145,000**	**$600,000**

BUDGET CONTEXT - EXPENDITURES BY FUNDING SOURCE AND FISCAL YEAR (FY)						
ADMINISTRATION:						
A.	**Estimated total mental health expenditures <u>for ADMINISTRATION</u> for the entire duration of this INN Project by FY & the following funding sources:**	**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**TOTAL**
1.	Innovative MHSA Funds	**$120,000**	**$167,500**	**$167,500**	**$145,000**	**$600,000**
2.	Federal Financial Participation					
3.	1991 Realignment					
4.	Behavioral Health Subaccount					
5.	Other funding*					
6.	**Total Proposed Administration**					
EVALUATION:						
B.	**Estimated total mental health expenditures <u>for EVALUATION</u> for the entire duration of this INN Project by FY & the following funding sources:**	**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**TOTAL**
1.	Innovative MHSA Funds					
2.	Federal Financial Participation					
3.	1991 Realignment					
4.	Behavioral Health Subaccount					
5.	Other funding*					
6.	**Total Proposed Evaluation**					
TOTAL:						
C.	**Estimated TOTAL mental health expenditures (this sum to total funding requested) for the entire duration of this INN Project by FY & the following funding sources:**	**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/33**	**TOTAL**
1.	Innovative MHSA Funds					
2.	Federal Financial Participation					
3.	1991 Realignment					
4.	Behavioral Health Subaccount					
5.	Other funding*					
6.	**Total Proposed Expenditures**	**$120,000**	**$167,500**	**$167,500**	**$145,000**	**$600,000**
*If "Other funding" is included, please explain.						