help @ hand™ Evaluation

Mental Health Services Act (MHSA) Innovation Technology Suite Evaluation

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University of California, Irvine

Year 2 (Quarter 2) Evaluation Report
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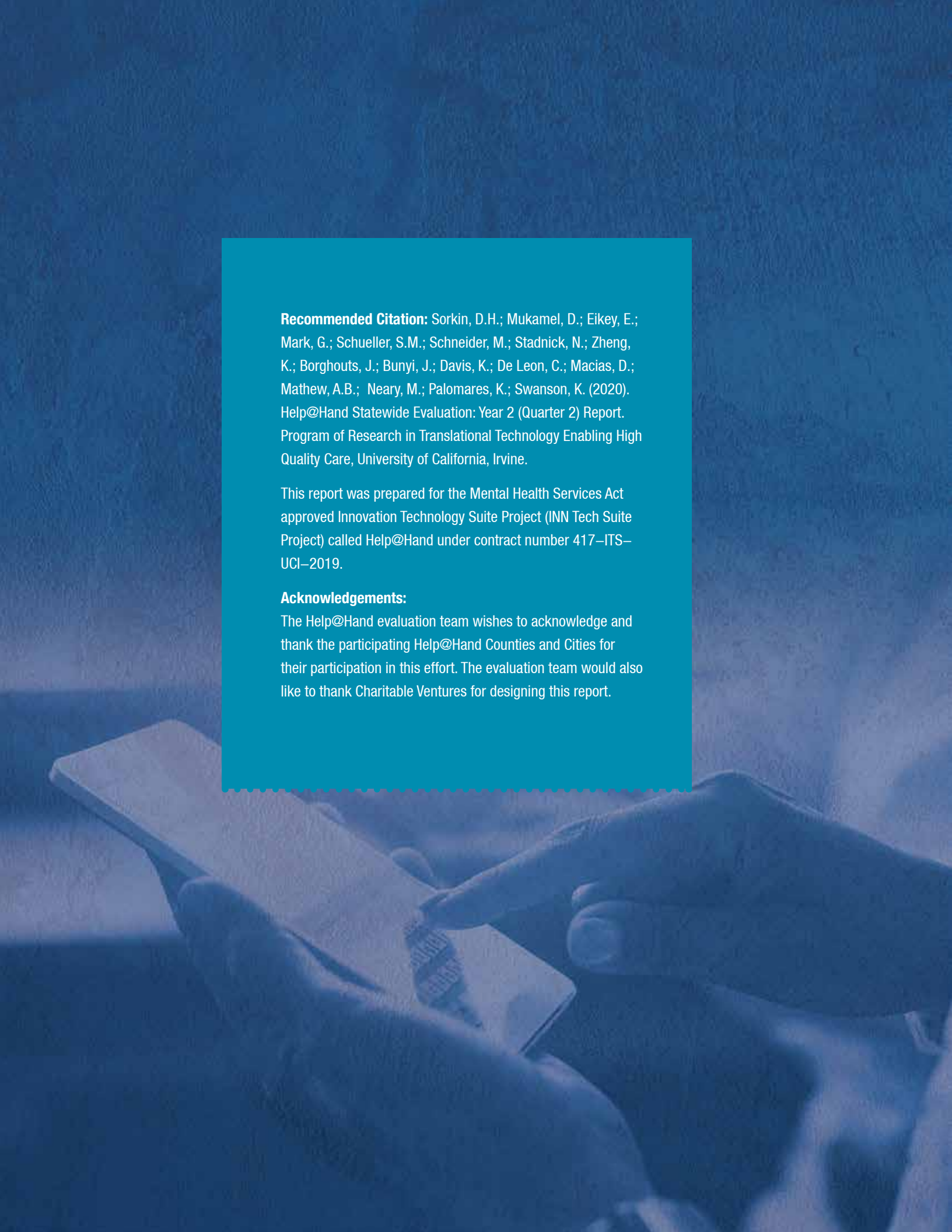

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INTRODUCTION

The tremendous impact of the global COVID-19 pandemic on the physical and mental health status and the economic security of individuals across Counties/Cities began in March 2020 and continued through Quarter 2 (April-June 2020). Counties/Cities services, including County Behavioral Health were immediately thrust into making operational changes to slow down the spread of the coronavirus, while taking critical steps to secure the health and safety of their employees and communities as a top priority.

Additionally, this period was marked by worldwide protests, and in some cases civil unrest, as a result of police brutality and the death of George Floyd and other people of color. Across California, the nation, and the world, there has been an increase in the awareness of institutionalized racism, discrimination, and incidents of police brutality and racially motivated violence against African-American and Black people, sparking ever more dialogue and social justice movements.

Together, these events, and their contributing and subsequent stressors (e.g. high rates of employment, rapid transition of children into distance learning) have contributed to significant and sustained mental health symptoms (see https://www.healthline.com/health-news/what-covid-19-is-doing-to-our-mental-health).

Within this context, Help@Hand Counties/Cities have been tirelessly working to transition their programs to continue their work remotely. This work, and related efforts around the Help@Hand program, is described below:

KEY HELP@HAND EVALUATION ACTIVITIES AND LEARNINGS (APRIL-JUNE 2020)

System Evaluation

Market Surveillance

This quarter the market surveillance team reviewed peer chat apps. Peer chat apps were defined as an app that allowed users to give and receive support from other users ("peers") on the app through messaging forums, chatrooms, or 1-on-1 chats. The team identified and reviewed 22 peer chat apps.

Some findings were similar to those noted in past reviews, such that peer chat apps had:

- Limited content that is tailored to specific target populations; and
- Insufficient accessibility features in general, making these apps inaccessible for people with various impairments.

Unlike past reviews, the review conducted this quarter also found the following:

- There is a lack of engaged and active membership communities on these apps, which undermines how an active peer community is an integral component and benefit of peer chat apps; and
- There is a lack of offline accessibility because users need internet connectivity to engage with others, which can present challenges to use for those with limited data plans.

Given these findings, it is recommended that Counties/Cities carefully consider how potential peer chat apps meet the needs of their target populations.

In addition to peer chat apps, the market surveillance team also reviewed apps with COVID-19 related content in order to help Counties/Cities navigate well-established and popular free apps that may help their communities during the pandemic. The review can be found in **Appendix D**.

County/City and Site-Level Implementation Evaluation

Pilot Evaluation: County/City and Site-Level Implementation

Orange and Riverside Counties launched noteworthy implementation efforts this quarter. In both Counties, evaluation efforts focused on understanding site-level (inner context) influences on implementation. Riverside also conducted additional data collection to explore the user experience (discussed in greater detail below, see *User Experience and Technology Evaluation)*.

Specifically, the Help@Hand evaluation team worked with both Counties to understand their implementations, as well as identify learnings and recommendations. Semi-structured interviews were conducted with both clinicians involved in Orange County's Mindstrong implementation. Riverside County developed a survey that they sent to the 12 Peer Operators and four clinicians who worked on their Take My Hand platform. Eleven of the Peer Operators responded to and completed interviews conducted by the Help@Hand evaluation team. Both Counties will work with the Help@Hand evaluation team to analyze the data. Findings will be presented in the next quarter report.

Peer Program Evaluation

The evaluation team tracked Peer Program activities through 13 interviews across 12 Counties/Cities this quarter. Interviews were conducted with Peer Leads and Tech Leads for those Counties/Cities with no Peer Lead. Thematic analysis of the interview data is underway and findings will be reported in the next quarter report.

User Experience and Technology Evaluation

Technology Exploration, Selection, and User Pilot Evaluation

User experience and technology evaluation efforts this quarter included working closely with the Help@Hand Collaborative to explore potential apps and plan user evaluations for upcoming pilots.

- San Mateo and Marin Counties worked with CalMHSA and the Help@Hand evaluation team to explore potential technologies to pilot. Surveys and/or focus group protocols were developed to support exploration of each technology considered. Marin County conducted focus groups with members of their target population to gather feedback from potential users and inform selection of appropriate technologies to pilot.
- Tehama County and Tri-City identified potential apps to pilot in their target populations. With support from CalMHSA and the evaluation team, Tehama County and Tri-City began planning their pilots. This involved developing their pilot proposal and evaluation plans as well as identifying and responding to potential risks and opportunities.
- Orange County launched their Mindstrong implementation this quarter with support from CalMHSA, the evaluation team, and various other experts. Key activities involved: developing consent form and recruitment processes in light of COVID-19; planning evaluation activities, such as collecting data from Mindstrong and electronic medical records as well as user surveys and interviews; and gathering data from piloting providers.
- Riverside used the Rapid Response framework to launch Take my Hand, a peer-chat support platform. Key activities involved: completing build-out on site (i.e., finalizing terms of service), developing training manuals, preparing and supporting workforce (i.e., training Peers, transitioning schedules), developing and implementing marketing materials, developing and implementing evaluation activities, obtaining County signed approval.
- Los Angeles County used the Rapid Response framework to launch Headspace across Los Angeles County. The Rapid Response framework allowed these technologies to quickly be deployed to support communities during COVD-19. Evaluation data was also collected to inform further implementations of these technologies.

Learnings from these efforts included:

- Counties/Cities can learn a lot from each other on how to improve their own processes – both for ongoing and future technology exploration and selection as well as their pilots.

- Help@Hand uses standardized measures, which are useful to draw comparisons. However, pilot plans, target populations, and technologies vary tremendously across each County/City. Thus, instruments must standardize as well as tailor measures to reflect a County/City's unique goals, target audiences, chosen technologies, and implementation approach.
- An individual County/City can gather helpful feedback from potential users during the technology exploration and selection stage by using systematic approaches and tools. Feedback gathered can inform decisions of the County/City's as well as other Counties/Cities who have a similar target audience or who are interested in the same technologies.

College Student Survey

A survey also was conducted in partnership with Los Angeles County and El Camino College (a community college in Los Angeles County) to identify students' unmet mental health needs and how technology can help meet these needs. Preliminary learnings from the survey indicated the following:

- Most students have access to a smartphone, WiFi, and a data plan to use mental health apps. However, most had never used a mental health app before and only half of those students were interested in using one;
- Stress, depression, and anxiety were the most prevalent mental health concerns among survey respondents;
- The most common strategies/resources used to manage health were informal, but respondents indicated they would like to use professional services. They would also like resources to help them to work through negative emotions and thoughts, identify and recognize symptoms, and talk with other people to get/give support;
- Common barriers to accessing mental health resources were financial reasons and privacy concerns. Important aspects for respondents about using mental health apps were that the app was free, and that personal information would be kept private; and
- Many students reported using informal strategies such as listening to music and playing games to manage their mental health. These could provide insight into potential areas to explore for outreach efforts and possibly ways to integrate mental health into other spaces and conversations on campus.

Outcomes Evaluation and Data Dashboard

Outcomes Evaluation

In April 2020, the Help@Hand evaluation team launched a national survey on Amazon Mechanical Turk (MTurk) to explore how different mental illness labels effect an individual's stigma. The survey also examined mental health symptoms as well as mental health technology use and usefulness. A total of 4,344 surveys were completed this quarter. Preliminary findings reveal:

- The labels of mental illness, mental health problem, and psychological disorder do not differ from one another when used to measure mental health stigma. However, when the label emotional distress is used or when the individual fills in a label, the resulting stigma measure can be significantly different from the other terms.
- Levels of depression and anxiety, as measured by the Patient Health Questionnaire (PHQ-9) and the General Anxiety Disorder scale (GAD-7) respectively, are uniformly high across Help@Hand Counties/Cities, the rest of California, and in the entire United States survey sample.
- Rates of mental health technology use varied across the Help@Hand Counties/Cities, the rest of California, and the entire United States survey sample. Those who used a mental health online forums or communities, mental health websites and apps, or phone-based or text-based crisis lines found it useful 89-98% of the time.

Additionally, the Help@Hand evaluation team worked with the Help@Hand Collaborative to continue collecting data from multiple sources, including the California Health Interview Survey (CHIS), California Health and Human Services (CHHS), County/City systems, and Technology Vendors.

Recommendations

Recommendations for the overall Help@Hand Collaborative and the individual Help@Hand Counties/Cities were developed based on evaluation activities and learnings. These recommendations are provided on pages 60 and 61.

INTRODUCTION

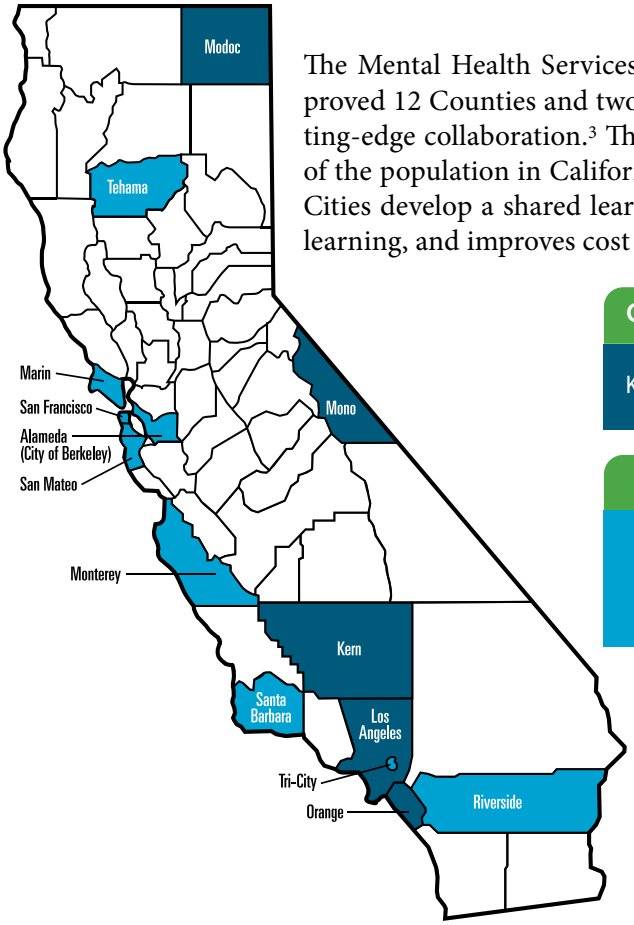
help @ hand™ Evaluation

Help@Hand is a five-year[1] statewide collaborative demonstration project funded by Prop 63 (now known as the Mental Health Services Act) and has a total budget of approximately $101 million. It is designed to bring interactive technology–based mental health solutions into the public mental health system through a highly innovative set (or "suite") of mobile technologies. The project intends to provide people across California with free access to mobile technologies designed to provide: education on the signs and symptoms of mental illness, including emotional/behavioral destabilization; connection to help in real-time; and access to mental health services when needed. In addition, Help@Hand leads innovation efforts by integrating Peers[2] throughout the project.

Through these efforts, Help@Hand focuses on five shared learning objectives:

1. **Detect and acknowledge mental health symptoms sooner;**
2. **Reduce stigma associated with mental illness by promoting mental wellness;**
3. **Increase access to the appropriate level of support and care;**
4. **Increase purpose, belonging, and social connectedness of individuals served;**
5. **Analyze and collect data to improve mental health needs and service delivery.**

[1] The project was originally designated as a 3-year effort.
[2] Help@Hand defines a Peer as a person who publicly self-identifies with having a personal lived experience of a mental health/co-occurring issue accompanied by the experience of recovery. A Peer has training to use that experience to support the people they serve.



The Mental Health Services Oversight and Accountability Commission (MHSOAC) approved 12 Counties and two Cities across the state of California to participate in this cutting-edge collaboration.[3] These Counties and Cities collectively represent nearly one-half of the population in California. By working as a collaborative, participating Counties and Cities develop a shared learning experience that expands technology options, accelerates learning, and improves cost sharing.

Cohort #1 Counties:

Kern County, Los Angeles County, Modoc County, Mono County, Orange County

Cohort #2 Counties/Cities:

Marin County, Monterey County, Riverside County, San Francisco County, San Mateo County, Santa Barbara County, Tehema County, Tri–City, and City of Berkeley

ABOUT THE EVALUATION

The University of California, Irvine (UCI) in partnership with the University of California, San Diego (UCSD) is conducting a comprehensive formative evaluation of Help@Hand. The evaluation involves observing and evaluating the project as it happens in order to provide real-time feedback and learnings.

The following evaluation report presents activities and findings for Quarter 2 (April-June 2020) of Year 2 of the project. The report is organized as follows:

- **Summary of Activities: Describes key activities and milestones accomplished during the period.**
- **Evaluation: Details evaluation activities and findings related to:**
  - o System Evaluation
  - o County/City and Site-Level Implementation Evaluation
  - o User Experience and Technology Evaluation
  - o Outcomes Evaluation and Data Dashboard
- **Recommendations: Presents recommendations based on findings.**

[3] Counties and Cities can join the collaboration by submitting a proposal to the Mental Health Services Oversight and Accountability Commission. Upon approval, Counties and Cities enter the collaboration by contracting with CalMHSA, which serves as the administrative and fiscal intermediary for the project. Inyo County joined the collaboration in 2018, but transitioned out due to insufficient internal resource capacity.

SUMMARY OF ACTIVITIES

The following timeline reflects key Help@Hand project activities during the quarter. It is not intended to be a comprehensive accounting of all activities. Appendix A include detailed County/City reported information, including key accomplishments during the quarter, lessons learned, and recommendations.

APRIL 2020

Oversight and Help@Hand Leadership

- Developed a rapid response option for Counties/Cities to deploy a rapid response solution in response to COVID–19
- Reviewed and approved 3 pilot proposals received from Los Angeles County
- Clarified expectations for local funds in project budget
- Began recruiting for a new Peer and Community Engagement Manager

County/City Activities

- Launched Headspace Rapid Response in light of COVID–19 and received media coverage (Los Angeles County)
- Launched Take my Hand in response to COVID–19 and received media coverage (Riverside County)
- Continued to work on Wysa contract negotiation and pilot planning (Tri–City)
- Planned Headspace pilot (Santa Barbara County)
- Began planning user testing of myStrength, Uniper, and Happify (Marin County)
- Released Screening Tool Request for Information (RFI) (Monterey & Los Angeles Counties)
- Began review of peer chat apps (Help@Hand evaluation team)
- Deployed college student survey at El Camino College (Los Angeles County, Help@Hand evaluation team)
- Deployed survey on Amazon Mechanical Turk (Help@Hand evaluation team)

Project Management

- Published Product Profiles to consolidate key information about RFSQ products and vendors
- Researched current product certifications, licensures, and other accreditation
- Began discussions on document translation expectations
- Developed and shared project onboarding materials for new Collaborative members

Other

- Published Stakeholder Report on Help@Hand website (helpathandca.org)
- Held Peer Collaboration meeting
- Held Evaluation Advisory Board meeting

MAY 2020

Oversight and Help@Hand Leadership

- Began discussions on revised evaluation scope of work and budget for approval
- Approved California Health Information Survey contract extension
- Revisited project budget model
- Happify announced it will not be available for new pilots
- Approved and published grievance policy on Help@Hand website (helpathandca.org)

County/CIty Activities

- Launched Mindstrong (Orange County)
- Presented at MHSA INN Community Planning Meeting on Lifeline phone testing to access online mental health resources (Orange County)

The tremendous impact of the global COVID-19 pandemic on the physical health, mental health, and economic security of individuals across Counties/Cities began in March 2020 and continued throughout quarter 2 (April-June 2020). Another major event this quarter was worldwide protests, and in some cases civil unrest, as a result of police brutality and the death of George Floyd and other people of color. While raising awareness and sparking dialogue on race issues, these events also contributed to a need for mental health and other much needed services for several communities. Help@Hand Counties/Cities worked tirelessly to plan, and in some cases launch, technologies to help people with their unmet mental health needs. CalMHSA, the Help@Hand evaluation team, and other experts provided Counties/Cities much support in the endeavors.

APRIL 2020

To help Counties/Cities quickly respond to the mental health needs of their communities during COVID-19, the Help@Hand Leadership developed a rapid response option for Counties/Cities. The Rapid Response framework offered an opportunity to accelerate technology implementation and availability for target populations and even the public if desired. Two Counties – Los Angeles and Riverside – launched efforts via the rapid response option.

Although Los Angeles County presented 3 pilot proposals in March 2020 and received approval by Help@Hand Leadership in April 2020, these pilots were put on hold. The County made the choice to prioritize their partnership with Headspace to offer free Headspace Plus to all County residents. The effort referred to as Headspace Rapid Response launched at the end of April and garnered media attention.

Riverside County deployed Take my Hand, its own peer chat platform, in mid-April to support County residents during COVID-19. The platform utilized trained Peer Specialists to operate chats 24/7 and on-call providers to offer crisis interventions when needed. Take my Hand received local media attention.

- Cancelled mental health awareness events and survey distribution at Santiago Canyon College and Angel Stadium due to COVID–19 (Orange County)
- Continued offering Headspace Rapid Response and receiving media coverage (Los Angeles County)
- Began negotiating contract with MindLAMP to replace MindStrong for electronic diary card in Dialectical Behavior Therapy (DBT) program (Los Angeles County)
- Updated and adapted Peer-developed Digital Mental Health Literacy Modules (Los Angeles County)
- Continued offering Take my Hand and receiving media coverage (Riverside County)
- Designed Take my Hand communication materials and videos (Riverside County)
- Began exploring additional apps to offer target populations (Riverside & San Mateo Counties)
- Began planning myStrength pilot (Tehama County)
- Closed Screening Tool RFI (Monterey & Los Angeles Counties)
- Announced hold pattern to focus on COVID–19 and planning for fiscal impact (Santa Barbara)

Project Management

- Added new implementation team member to the project management team
- Member of CalMHSA's product team transitioned off project
- Updated curated COVID–19 resources sheet
- Began plans to test SmartSheet, a project scheduling tool, for Help@Hand
- Added a subscription link on Help@Hand website for the public to receive project announcements and updates

Other

- Held Peer Picnic Collaboration meeting

JUNE 2020

Oversight and Help@Hand Leadership

- Continued discussions of revised evaluation scope of work and budget for approval
- Continued review of Collaborative budget

County/CIty Activities

- Continued offering Headspace Rapid Response (Los Angeles County)
- Continued Take my Hand deployment and interviewed Peer Operators (Riverside County, Help@Hand evaluation team)
- Continued Mindstrong implementation and interviewed piloting providers (Orange County, Help@Hand evaluation team)
- Held Digital Mental Health Literacy virtual trainings for service extenders, community health workers, and Peers (Los Angeles County)
- Presented at MHSA INN Community Planning Meeting on Lifeline phone testing to access online mental health resources (Orange County)
- Held user testing focus groups for myStrength and Uniper with older adults (Marin County)
- Began exploring products to pilot (San Francisco County)
- Personalized Digital Mental Health Literacy training (Tri–City)
- Focusing on Peer Ambassador Program (Santa Barbara County)
- Began developing plans for Headspace Rapid Response (San Mateo County)
- Conducted Peer interviews with 12 Counties/Cities (Help@Hand evaluation team)

Project Management

- Resignation of a member of CalMHSA's product team
- Presented "Hybrid Pilot Implementation" process
- Developed Recommended Staff Expertise for Help@Hand Guide and Vendor Status Updates

Other

- Held Peer Collaboration meeting
- Full DMHL video series made available on Help@Hand website (helpathandca.org/dmhl)
- Year 2 (Quarter 1) Help@Hand evaluation report made available for internal distribution
- Resignation of two members of Help@Hand evaluation team

Other Counties/Cities focused on preparing for pilots. Santa Barbara County planned a Headspace pilot with transition age youth (TAY) in colleges and universities; certain isolated adult clients; and adults discharged from psychiatric hospitals or who received crisis services. Marin County planned user testing of myStrength, Uniper, and Happify with isolated older adults, their target population, in order to inform which technology to pilot. San Francisco County contracted with Mental Health Association to support their app exploration.

Meanwhile, Monterey County, in partnership with Los Angeles County, released their Screening Tool Request for Information (RFI) to help identify a vendor to design and develop an evidence-based assessment tool. The tool is designed to screen for a broad spectrum of mental health disorders and refer individuals to the appropriate level of care within the local mental health system. The RFI was sent to BidSync and potential vendors.

In addition to supporting Counties/Cities in their various efforts, CalMHSA and the Help@Hand evaluation team performed a number of program administration activities in April 2020. CalMHSA clarified expectations on how local County/City funds could be used; began recruitment for a Peer and Community Engagement Manger; and published a stakeholder report on the Help@Hand website (helpathandca.org). CalMHSA's project management team developed and shared: product profiles with key information on RFSQ products and vendors; an assessment of the certifications, licensures, and other accreditations currently available to healthcare technology companies and their apps for consumers; and project onboarding materials, particularly for new Collaborative members. They also held the Peer Collaboration meeting and facilitated discussions on the expectations and potential process for document translation. The Help@Hand evaluation team: held an Evaluation Advisory Board meeting; began reviewing peer chat apps for the market surveillance; and deployed two surveys from April – June 2020. One survey assessed the mental health needs of college students at El Camino College and was done in collaboration with Los Angeles County. The other examined the impact of mental health related labels across Help@Hand Counties/Cities and the nation.

MAY 2020

After more than a year of extensive planning, Orange County launched its Mindstrong implementation with psychiatric patients seen at UCI Health Psychiatry Services. In addition, Orange County presented a proposal to test access to online mental health resources

on Lifeline phones at their MHSA INN Community Planning meeting. Unfortunately, Orange County had to cancel two mental health awareness events – one at Santiago Canyon College and the other at Angel Stadium due to COVID-19 social gathering restrictions. Both events would have included the distribution of surveys to understand the mental health needs of target populations.

Los Angeles and Riverside Counties continued the launch of Headspace Rapid Response and Take my Hand, respectively. They continued to receive media attention. Los Angeles also updated and adapted their Peer-developed Digital Mental Health Literacy Modules for virtual training sessions. Riverside County designed communication materials for Take my Hand, such as YouTube videos and a newsletter entitled "ChatVox."

Both Counties looked to pursue additional technologies. Monterey and Los Angeles Counties closed the RFI released in April 2020 and began to analyze information in order to develop a Request for Proposal (RFP) for procurement. Los Angeles County also began negotiating a contract with MindLAMP to replace Mindstrong in providing electronic diary cards in their Dialectical Behavior Therapy (DBT) program. Riverside began exploring additional apps to offer their target populations, particularly their deaf and hard of hearing population.

Exploring apps and planning pilots began in other Counties/Cities. City of Berkeley contracted and on-boarded local consultants to support their app selection and pilot. San Mateo County began exploring apps for their target populations – TAY and older adults. Tehama County began planning myStrength for: 1) homeless; 2) isolated adults; and 3) existing clients. Tri-City continued planning their pilot with their transitional aged youth (TAY) are currently engaged in their wellness center programs. Pilot planning involved several activities, including but not limited to, completing the pilot and evaluation proposal (the proposal details their plans and must be approved by Help@Hand Leadership before launching their pilot); the Digitial Behavioral Health Questionnaire (a risk assessment tool); and the Exploration Training Report (a tool to identify potential defects). Tri-City also began contract negotiation with Wysa.

While several Counties/Cities focused on technology implementations, Santa Barbara County announced a hold pattern in order to direct their focus on COVID-19 and planning for its fiscal impact. COVID-19 also impacted the availability of Happify for new pilots. Happify would not begin any new contracts, stating "Given the enormous shift that this pandemic has had on our business, we've found ourselves having to prioritize supporting our current employer and health plan clients."

In terms of program administration, the Collaborative and the evaluation team began discussing updates to the evaluation scope of work and budget given shifting project priorities and the newly adopted Collaborative budget model. The Help@Hand Leadership approved the grievance policy process and approved a contract extension with California Health Information Survey (described in the Outcomes and Data Dashboard chapter on page 58). Project management activities included: updating a curated COVID-19 resource sheet; initiating plans to test SmartSheet, a project scheduling tool, with Tri-City; and adding a subscription link on the Help@Hand website to improve external communication by allowing the public to easily receive project announcements and updates. It is also important to note that a member of the CalMHSA product team transitioned off the project. Lastly, CalMHSA hosted a virtual "Peer Picnic," which involved modifying the monthly Peer Collaboration meeting. The picnic was well-received and had 21 Peers in attendance.

JUNE 2020

Los Angeles, Riverside, and Orange Counties continued to implement Headspace Rapid Response, Take my Hand, and Mindstrong, respectively. All three Counties, with support from CalMHSA and the Help@Hand evaluation team, assessed their implementations as described in great detail throughout this report. Assessments were multi-faceted, involving collection of data from users, those involved in implementation, electronic medical records, and/or the technology itself. As part of these assessments, the Help@Hand evaluation team interviewed clinicians involved in Orange County's Mindstrong initiative and Peer Operators involved in Riverside's Take my Hand deployment (described in the County/City and Site-Level Implementation Evaluation chapter of this report). Additionally, Los Angeles County held Digital Mental Health Literacy virtual trainings for service extenders, community health workers, and Peers. Orange County presented a second time to their MHSA INN stakeholders for buy-in to evaluate access to online mental health resources on Lifeline phones.

Several Counties/Cities proceeded with planning technology efforts. Marin County stated conducting a number of virtual user testing focus groups for myStrength and Uniper with older adults. San Francisco

SPOTLIGHT: GRIEVANCE POLICY

The Help@Hand Collaborative developed a policy to address grievances by consumers and other stakeholders.

In every program, there will be customers who report having a negative experience. Customer complaints may not always be a sign that something is wrong. Nonetheless, credence must be given to every message that is shared by a customer, as feedback from customers can be turned into learning opportunities. As Brittany Ganguly, CalMHSA Program Manager, noted, "A collaborative wide grievance policy was important to develop so that all community members, participants of Help@Hand and stakeholders have a communication channel with the collaborative."

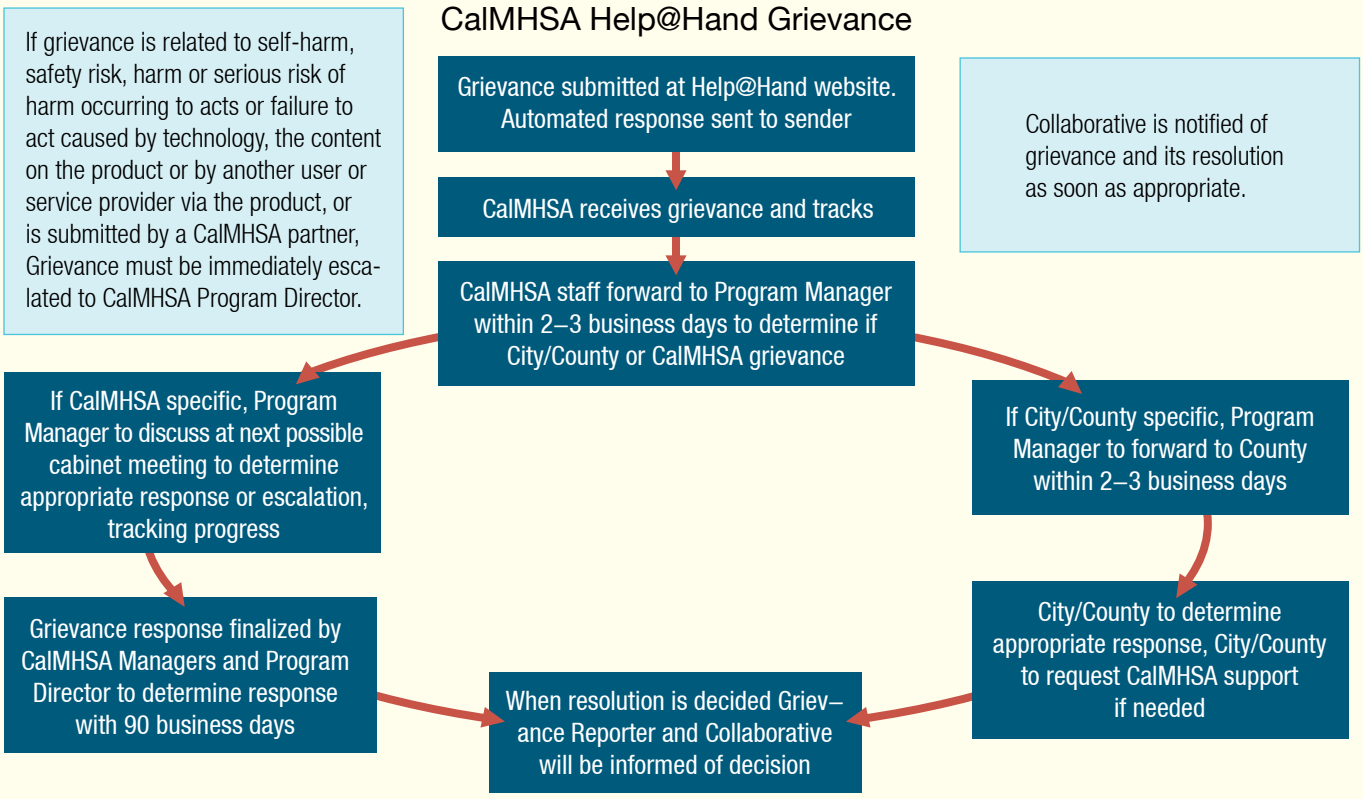
CalMHSA developed and the Help@Hand Collaborative approved a formal grievance policy to allow any individual to report a grievance or issue to be resolved in a safe and fair environment. It determines escalatory criteria as well as how grievances will be directed and carried to resolution. The policy allows grievances to be submitted to CalMHSA on behalf of program wide matters related to Help@Hand and/or the use of technology in mental health systems. Any grievances that are County/City specific will be handled directly by that County/City. This includes implementation of a product, use of funds, choice and use of technology, or any other County/City specific items. The policy is particularly noteworthy because it aligns with the grievance requirements of each individual Help@Hand County/City.

Below is the grievance process. The process involves:

1. Grievances can be submitted at the Help@Hand website (Helpathandca.org) by filling out a form via the "Grievance Submission" section on the "Contact Us" page. The individual sending the grievance will receive an automated response detailing expectations for the response.
2. If a grievance is related to self-harm, harm to others, other safety risks, or submitted by a CalMHSA contractor or project partner, the grievance will be immediately escalated to the CalMHSA Director and, if possible, the County/City where the user resides will be notified. All other grievances will be addressed by the CalMHSA Help@Hand Program Manager within 90 business days. For grievances specific to a County/City, the CalMHSA Program Manager will work with the appropriate County/City and/or Mental Health Services Act (MHSA) office to find a resolution.

The final version of the policy was presented to the Leadership Committee on April 16th and approved on May 5th.

Grievance Process Guidelines



County worked on identifying potential technologies to pilot. San Mateo continued to examine potential apps for their TAY and older adult populations. San Mateo County also began plans for a Headspace Rapid Response similar to Los Angeles County.

Tehama County and Tri-City continued to plan their pilots. They also looked at improving communication. Regular interdepartmental check-ins within their agencies about the project were instituted in order to keep everyone updated. In addition, Tehama County and Tri-City planned to customize the DMHL training to better meet the needs and communicate with their target populations. In particular, Tehama County looked into how best to condense the training and market it for their target population. Tri-City planned to condense the cyberbullying training and to present the training during a monthly Community Connection event.

Although not planning to implement technology, Santa Barbara County began developing a Peer Ambassador Program. The program involves creating Digital Wellness Ambassador materials; teaching a literacy curriculum at clinics, community centers, community-based organizations, adult housing, recovery learning centers, online spaces, and possibly other venues; and link individuals to low cost laptops, phones, and WIFI.

Discussions on the revised evaluation scope of work and budget as well as the Collaborative budget continued in June 2020. For the latter, CalMHSA scheduled two Leadership meetings on June 11th and 25th in order to dedicate time toward discussing and answering questions related to the overall Collaborative budget. The CalMHSA project management team developed and shared the "Hybrid Pilot Implementation" process, a planning tool to help ensure Counties/Cities fulfill required pilot activities while offering flexibility to streamline their implementation timeline; the Recommended Staff Expertise for Help@Hand, a guide developed based on lessons learned to date that outlines the recommended internal experts Counties/Cities should involve on their project; and the Vendor Status Update, a document with updates and announcements related to product offerings. Peer-related activities involved: convening the monthly Peer Collaboration meeting; publishing the full DMHL video series on the Help@Hand website (helpathandca.org/dmhl); and participating in interviews with the Help@Hand evaluation team aimed at documenting the Help@Hand Peer Program. In addition, the Year 2 (Quarter 1) Help@Hand evaluation report was made available for internal distribution. Finally, there was turnover within CalMHSA and the evaluation team, with resignations from a member of CalMHSA's product team and two members of the evaluation team.

SPOTLIGHT: ORANGE COUNTY

Orange County Health Care Agency's Mindstrong Implementation

Since their approval to join the Help@Hand Program in 2018, Drs. Flor Yousefian Tehrani, MHSA Innovation Projects Program Manager, and Sharon Ishikawa, MHSA Coordinator, have been systematically following and maintaining an organizational change management plan to guide Orange County Health Care Agency's (HCA) implementation of Mindstrong. In June 2020, Mindstrong officially enrolled its first member from Orange County as part of this program.

Along the road to implementing their plan, Orange County has learned a number of lessons. Below Dr. Sharon Ishikawa highlighted three major lessons learned. Appendix B on page 79 provides more detailed lessons learned.

Lesson #1: *It takes a village to make changes to a County/City Behavioral Health System*

Building a digital system of care within a County/City Behavioral Health System requires the input, guidance, and sign-off of many people both within the system and across the diverse team of people designed to support project management, implementation, and evaluation. Orange County's village included:

- **Project Leadership (Tech Leads, Behavioral Health Director, and, as needed, Directors from Behavioral Health and different systems of care)** was responsible for local stewardship and decision-making, especially on clinical integration, risk management, privacy concerns, prioritization of efforts and use of funds.

- **Project Team (Orange County staff)** was responsible for executing different aspects of the project (i.e., informed consent, etc.).
- **Project Management Vendor (Cambria Solutions, Inc.)** was responsible for developing the business processes, managing the project meetings, developing collateral materials and project information for consumers and stakeholders, and identifying issues and risks.
- **HCA's Help@Hand Peers** were responsible for providing insight and feedback on business processes, collateral materials, and information developed for consumers. They will consent referred consumers as soon as all equipment and access/permissions related to personal health information (PHI) and personal identifiable information (PII) are in place.
- **HCA's Compliance** was responsible for providing guidance, input, and direction on informed consent, business associate agreement (BAA), privacy and security issues, and business process.
- **HCA's Public Information Officer (PIO)** was responsible for reviewing public-facing documents, collateral materials, and the Informed Consent website.
- **HCA's Information Technology (IT) Security** was responsible for vetting IT security of the Mindstrong platform, as well as providing solutions and ideas for technical issues such as capturing informed consent records that contain PHI/PII.
- **HCA's AQIS (Authority and Quality Improvement Services)** offered guidance on HCA's grievance policy, which was used to inform the development of CalMHSA's Help@Hand grievance policy.
- **HCA's Purchasing** was responsible for assisting with review of scope of work (SOWs) and procurement of services and vendors.
- **HCA's Peer Employee Advisory Committee (PEACe)** provided feedback and insight in selecting an appropriate voiceover for the Mindstrong video.
- **HCA's Chief Information Officer (CIO)** was responsible for guidance and direction on technical solutions.
- **Providers (UCI Health Psychiatry Services)** were responsible for referring eligible consumers and helping to coordinate the business process integration into their systems and processes.
- **Mindstrong** was responsible for the technology and corresponding support services delivered to consumers, providing technical assistance for the process development, and ensuring implementation works with the application/services and the business model.
- **Outside Vendors** supported services such as video production, web design, etc.

As a village, the group worked collaboratively on a number of vital areas and issues. For example, early discussion and engagement with the UCI Health Psychiatry Services Project Sponsor was critical in getting them to pilot Mindstrong and be an advocate for the implementation. Also, multiple parties, including project leadership from HCA, HCA Compliance, HCA IT, Cambria, UCI Health Psychiatry Services, and Mindstrong, conferred to develop the rapid deployment process of referral, informed consent, and enrollment. Another noteworthy example of collaboration was engaging HCA Compliance and HCA IT to brainstorm and address informed consent issues, such as content, process, and technology-based solutions. The team also spent much time crafting language that was easy to understand for the target audience.

Lesson #2: *"Perfection is the enemy of progress." -Winston Churchill*

It is important to figure out the best time to launch. Launching too soon or too early may jeopardize overall implementation because critical issues are not identified and/or do not have an appropriate level of contingency planning. Alternatively, there are always issues or barriers that can impede progress, and a perfect or flawless implementation plan is not achievable. To balance these, it is critical that Counties identify their core values and use those to guide the decision to launch a product. Orange County's core values included:

- **Consumer safety, privacy, and product quality were top priority.**
- **A hierarchy of safety and privacy** that consisted of: 1) Compliance/IT work to identify risks/potential risks; 2) eliminate known risks; 3) guard against unknown risks; and 4) advise users of identified risks so they can make an informed choice about whether to use.
- Ensure **product quality** by fully understanding the product, evaluating evidence of potential impact, and working closely with Mindstrong and the evaluator to identify appropriate metrics.

One example of demonstrating these principles was implementing a modified informed consent process, which allowed immediate implementation while the team continued to develop a long-term informed consent process. Originally, the team planned for Help@Hand Peers to consent a referred consumer in-person following their appointment. However, the plan was interrupted due to COVID-19. A modified informed consent process was developed, which involved the HCA team calling consumers to review a brief "Introducing Mindstrong" video and informed consent form before referring them to Mindstrong. This process helped to protect consumer safety by explaining services, the timeframe, and costs. The video was recommended by an HCA peer and communicates standard information. It also provides an opportunity for the team to answer any questions. The multi-modal delivery of information (visual, audio, written) helped ensure consumers received information in a mode that worked best for them.

Another example is that the pilot process soft-launched with two providers to gauge and understand process impacts and make necessary adjustments before opening up referral process to all UCI Health Psychiatry Services providers.

Lesson #3: *The journey is as important as the destination*

The learnings that have been extracted to date have been critical for building the foundation for continual organizational change for Orange County HCA. These deep learnings required time, patience, and a commitment to adhere to a general path and process, while maintaining flexibility to accommodate and address barriers as they arose. Ultimately, established processes to support the Mindstrong implementation will live beyond the lifetime of any single product and the Help@Hand project period by moving Orange County HCA closer to building a framework for a sustainable digital mental health system of care.

Examples of the types of processes addressed include:

#	Description	Contributors (in alphabetical order)[4]
1	Vet the safety and functionality of the vendor as well as tech–nology used (or being considered) to support implementation (i.e., Qualtrics,secure file transfer protocol, secure email, etc.) or privacy issues of methods (i.e., phones to call referred consumers – privacy of vmail/texting, etc.)	Cambria Project Team, Help@Hand Peers, Project Team, **HCA Compliance, HCA Leadership**, UCI Health Psychiatry Services, Mindstrong Important to note that while this activity is specific to Quarter 2, one of OC's first activities nearly two years ago was to have IT conduct a robust Information/Data Security vetting when Mindstrong was initially identified as a vendor
2	Engage stakeholders for outreach material support and digital literacy training support	**CalMHSA**, HCA Leadership, HCA Project Team, **Help@ Hand Peers**
3	Develop targeted Mindstrong outreach materials (materials tailored for providers and consumers)	**Cambria Project Team**, HCA Leadership, HCA Project Team, Help@Hand Peers, Mindstrong, **Outside Vendors**, PEACe, UCI Health Psychiatry Services
4	Develop an informed consent document that describes Mind–strong services and standardizes information reviewed with consumers. The document explains Mindstrong services, care coordination, data collection, privacy, security, crisis response, and consumer participation in the project (i.e., duration, cost, etc.)	Cambria Project Team, **HCA Compliance, HCA Leader-ship, Help@Hand Peers**, Mindstrong, PEACe, UCI Health Psychiatry Services
5	Develop an introduction to Mindstrong video to ensure review of product description and privacy (including, but not limited to, content, phrasing, actor selected for voice over, etc.)	**Cambria Project Team**, HCA Compliance, HCA Leadership, HCA Project Team, **Help@Hand Peers**, Mindstrong, **Out-side Vendors**, PEACe
6	Conduct change readiness assessment of programs/partners	**Cambria Project Team**, HCA Leadership, HCA Project Team
7	Consult with stakeholder groups for compliance review and crisis response	CalMHSA, Cambria Project Team, **HCA Leadership**, **HCA Compliance**, HCA Project Team, Mindstrong
8	Plan sustainability beyond the project period if implementation is successful	AQIS, Cambria Project Team, **HCA Leadership**, HCA Project Team, HCA IT, Help@Hand Peers, Mindstrong, Help@Hand Evaluation, UCI Health Psychiatry Services
9	Twice weekly (15–30 mins) touchpoint calls with HCA Tech Leads for decision making (esp. when COVID–19 dramatically decreased their availability for Help@Hand project)	**Cambria Project Lead**, HCA Tech Leads
10	Daily working meetings for Cambria project team to discuss project activity updates, scheduling, issue review and resolu–tion, project documentation update, risk analysis	**Cambria Project Team**
11	Weekly planning meetings with Cambria project, HCA project team and Help@Hand peers to plan ahead for the following week	**Cambria Project Team**, HCA Leadership, HCA Project Team, Help@Hand Peers
12	Regular project status meetings with partnering organizations, vendors, the Help@Hand Collaborative, and local project team	**Cambria Project Team**, HCA Leadership, HCA Project Team, Help@Hand Peers, Mindstrong, Help@Hand Evaluation, UCI Health Psychiatry Services
13	Document of meeting minutes, decisions, accomplishments, issues, risks and mitigation strategies for tracking and monitoring implementation status and maintaining records for current and future project decision-making	**Cambria Project Team**, HCA Project Team, Mindstrong, Help@Hand Evaluation, UCI Health Psychiatry Services

[4] Bolded contributors were the lead for the corresponding category.

1 SYSTEM EVALUATION

Key Points

- The Help@Hand evaluation team identified 54 peer chat apps and reviewed 22 that met specified inclusion criteria. Review findings included:
  - Features and functionality of the reviewed peer chat apps noted less robust accessibility features, lack of functionality when not connected to the Internet, and limited language availability. This might make these apps inaccessible to some groups, such as individuals with visual impairments, those with inconsistent Internet access, or non-English speakers.
  - Most peer interactions were moderated, but it was unclear by whom.
  - The use of such apps is low, which is especially problematic as the core feature of these apps require connecting users within the app to drive peer chats.
- Well-established and popular free apps with COVID-19 related content were also reviewed in order to help communities address issues arising from the pandemic. The review can be found in Appendix D.
- Conversations to proceed with a collaborative process evaluation, which aims to understand the factors facilitating or impeding Help@Hand at the organizational level and make recommendations to address these factors, occurred this quarter.

OVERVIEW

Multiple system-related factors can impact health and human services. These factors may influence the implementation, adoption, and use of Help@Hand technologies. This chapter focuses on evaluating system-related factors that may influence Help@Hand. It presents evaluation activities and learnings as follows:

- **Market Surveillance**
  - Peer Chat App Review
    - Feature Review: Accessibility
    - Feature Review: Content for Selected Target Groups
    - Feature Review: In-App Peer Support
    - Feature Review: Terms of Service and Community Guidelines
    - User Experience Review
    - Marketplace Data Review
  - COVID-19 App Discovery
  - Learnings from the Market Surveillance
- **Environmental Scan**
- **Collaborative Process Evaluation**

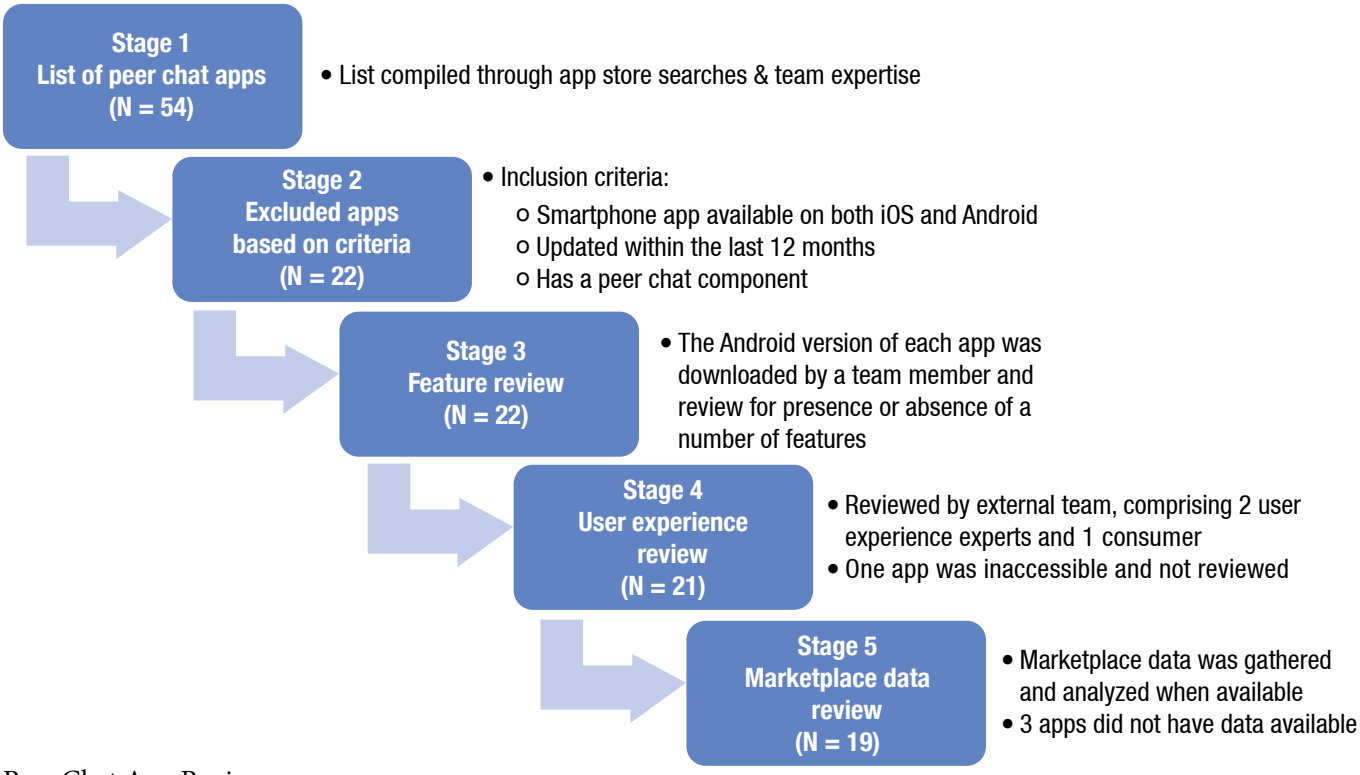
MARKET SURVEILLANCE

This quarter the market surveillance reviewed general trends in peer chat apps and comparisons between apps. Peer chat apps were defined as an app that allowed users to give and receive support from other users ("peers") on the app through messaging forums, chatrooms, or 1-on-1 chats. These apps were reviewed since several Counties/Cities expressed interest in piloting such products. It was also reviewed since peer chat is a main therapeutic focus of Help@Hand.[5]

In addition, the team performed an extensive search for well-established and popular free apps with COVID-19 content in order to help Counties/Cities identify and navigate options to support their communities.

[5] Three therapeutic focus areas were identified at the project's inception: (1) Peer Chat and Digital Therapeutics; (2) Virtual Evidence-Based Therapy utilizing an avatar; and (3) Digital Phenotyping using passive data for early detection and intervention.

Figure 1. Market Surveillance Review Stages for Peer Chat Apps



Peer Chat App Review

Figure 1 depicts the five review stages used this quarter. The stages include:

- Stage 1 and Stage 2: The evaluation team compiled a broad list of peer chat apps based on app store searches and the team's expertise in digital mental health. The team excluded apps not meeting the inclusion criteria which resulted in a final list of 22 apps.
- Stage 3: The team downloaded the 22 apps and explored individual app features to determine the presence or absence of various features. These included accessibility features and features of the peer intervention component of the app listed in Table 1. All apps were available on iOS and Android, but reviews were completed on an Android device.[6]
- Stage 4: The evaluation team had experts and consumers review the user experience of apps using the Mobile App Rating Scale (MARS), well-known, validated, and standardized tool that assesses the engagement, functionality, aesthetics, and information quality of health apps (Stoyanov et al, 2015).
- Stage 5: The team gathered marketplace data and usage trends from third-party analytics platform for those apps that had such data available.

This section describes key findings from: 1) feature review of accessibility, content for selected target groups, in-app peer support, and terms of services and community guidelines; 2) user experience review; and 3) marketplace data review.

It is worth noting that this review focused on peer chat smartphone apps, but there also are a number of websites facilitating peer communities around mental health. Some examples of web-based peer chat platforms are:

- Emotions Anonymous
- Support Group Central
- The Tribe Wellness Community
- ForLikeMinds
- 18percent
- Supportiv

[6] Android has a larger market share than iOS; in 2019, smartphones running the Android operating system held an 87% share of the global market (Statista, 2019). This may be because Android has a lower entry-level price point and broader price range than iOS and makes it more accessible for persons with lower socioeconomic status. Thus, the market surveillance team completed reviews on the Android version of each app as this is likely the version used by the majority of County/City users.

Table 1. Selected Feature and User Experience Reviews

App Name	Screen Reader Capabilities	Customizable Display Features			Offline Access	Number of Languages Available in App	Content for Selected Target Groups	In–App Peer Support							User Experience Scores (MARS)	
								Moderated chatroom	Unmoderated chatroom	Moderated forum	Unmoderated forum	1–on–1 peer messaging	Connect in–app with therapist	Referral available	Expert	User
Screen Reader Capabilities +++ All buttons spoken ++ Most buttons or features spoken, some exceptions + Some buttons or features spoken, some exceptions **Customizable Display Features** A- Text size T High contrast text ◑ Color inversion		**Is app content available offline?** Internet needed, no content available online Internet needed for chats, other content available offline														
365 Gratitude Journal	+	A-		◑		1	None			•					4.36	3.95
7 Cups	++			◑		34	LGBTQ+	•		•		•	•		3.44	2.75
DBT Coach	++	A-	T	◑		1	None		•	•					3.85	4.09
Habitica	++	A-				19	None	•		•		•			3.88	3.65
iPrevail	++	A-	T	◑		1	None			•		•			4.16	3.56
iRel8	++		T	◑		1	None				•	•		•	2.88	3.47
LGBT+ Amino	+	A-	T	◑		1*	LGBTQ+	•		•		•			3.51	3.7
OOTify	++	A-	T	◑		1	None			•			•	•	3.79	4.09
Pocket Rehab	++	A-	T	◑		1	None			•		•		•	4.07	3.28
rTribe	++	A-	T	◑		1	None	•				•	•		4.05	4.24
Sanvello	+++		T	◑		1	None			•			•		4.8	4.79
Sober Grid	++			◑		1	None			•		•			3.51	3.4
SoberTool	++	A-	T	◑		1	None			•					2.71	3.41
Solace	++	A-	T	◑		1	None	•		•					1.28	2.53
TalkLife	+	A-	T	◑		1	None			•		•			n/a	n/a
Therapeer	++		T	◑		1	None	•							4.23	3.9
Trill Project	+	A-	T	◑		1	LGBTQ+			•		•		•	3.44	3.64
Unmasked Mental Health	++	A-	T	◑		1	None					•			2.74	3.15
Wakie	++	A-	T	◑		1*	None	•		•		•			3.08	3.45
We Are More	++	A-		◑		1	People living with chronic disease			•		•		•	3.15	3.79
What's Up				◑		1	None			•					2.67	3.83
Wisdo	+++	A-	T	◑		1	None			•		•			3.38	4.25

*More languages available in iOS (see Appendix C)

Feature Review: Accessibility

Mental health apps that do not consider accessibility may widen gaps in access to care by only catering to able-bodied and well-resourced people. Mobile accessibility refers to making websites and apps easy to use for a broad range of people. The evaluation team reviewed accessibility features based on the W3C Accessibility guidelines (World Wide Web Consortium, 2018). These features include: 1) technological adaptations (i.e., assistive technology which allows people with disabilities to use the technology); and 2) other factors such as cost and availability in languages other than English.[7]

Assistive Technologies (Screen Readers, Customizable Display Features, Offline Access)

Screen readers translate text and image content into audio output. This can help people who are blind or visually impaired, illiterate, or have a learning or cognitive disability. The evaluation team rated the use of a screen reader for each app as shown in **Table 1**. Only one app reviewed (4.5%) had the screen reader function for all the buttons or features. The majority of the apps (n = 20; 90%) had the screen reader function for most or some of the buttons or features. One app (4.5%) had very unresponsive screen reader functionality. Screen reader functions are particularly important for peer chat apps, which are text-heavy.

A number of options for **customizing display** can help users with visual impairments or other needs. **Table 2** explains these features and shows the number of apps containing each feature. Most apps had customizable text size, high contrast text, and color inversion features, though these features were noted less frequently than the previous review of meditation apps.

Table 2. Customizable Display Features

Feature	Explanation	# of Apps with Feature (% of total, N = 22)
Customizable text size	Text size can be increased or decreased. This facilitates reading of text by people with mild visual disabilities, without requiring the use of a screen magnifier.	16 (73%)
High contrast text	Contrast between text and background can be adjusted to help readability for those with low vision.	16 (73%)
Color inversion	Color inversion swaps light colors for dark, which can help with eye strain. Being able to change the hue and color of a screen can help with readability for various visual challenges, though full color customization is ideal.	21 (95%)

The evaluation team considered offline access (i.e., whether or not content was available when offline) of apps reviewed since internet access and data plans may differ across and within Counties/Cities. By their nature, peer chat apps all required internet connectivity in order to connect with other users in real time (similar to the requirement of internet connectivity for social networking sites such as Snapchat or Facebook). Some apps did have other content available offline (i.e., assessments, mood-tracking, psychoeducation) (n = 10; 46%), but no chat features were available offline.

Cost

Only one app reviewed (4.5%) incurred a cost to download (99 cents). All other apps were free to initially download. Eleven apps had a premium, paid version available which contained additional features, including removal of ads, device syncing, enhanced privacy options, unlimited chatting, and coaching.

[7] This was not intended to be an exhaustive review of accessibility. For example, it did not include accessibility considerations such as cognitive accessibility (i.e., content designed for those with cognitive disabilities). Instead, the review looked at compatibility of the app with accessibility features available at the device level. Device-level accessibility will vary. The evaluation team reviewed accessibility features in this report on a Galaxy S7 and Pixel 2 (released in 2016 and 2017, respectively). Older devices may not have the same capabilities.

Language

The majority of apps (n = 20; 91%) were only available in English on Android (compared to 57% of meditation apps previously reviewed). Two apps reviewed were available in other languages (7Cups in 34 languages and Habitica in 19). Two apps reviewed had additional languages available in the iOS version (LGBT+ Amino, Wakie), but not Android. **Appendix C** includes the full list of languages on both platforms. Note that the availability of certain languages does not necessarily indicate that the app is culturally tailored, but rather that the content has been translated.

Feature Review: Content for Selected Target Groups

Three out of the 22 apps (14%) contained content specifically tailored for the LGBTQ+ community. One app (4.5%) had content for people living with chronic disease. The small number of apps with specially tailored content mirrors the pattern seen in the previous review of meditation apps. Note that while only a small number of apps had tailored content, users were free to interact on a range of topics and initiate conversations on culturally relevant topics.

Feature Review: In-App Peer Support

One challenge of reviewing "peer" apps is the definition of peer. Help@Hand defines peer as "a person with lived experience with mental health challenges and with the recovery process." In this review, the market surveillance team attempted to document how each app reviewed defined peer; however, this proved to be challenging. Not all apps were transparent with how they defined peers, and it was unclear if app users acting in a "peer" capacity had lived experience. In a small number of apps reviewed, peers were defined as trained "helpers" who could give advice based on training and their own experience, but the majority of apps did not provide any training for those providing support. An example of a trained peer model is TalkLife, where users are trained to "learn how to support others online including active listening, conveying empathy and self-care."

Not all apps were transparent with how they defined peers, and it was unclear if app users acting in a "peer" capacity had lived experience. In a small number of apps reviewed, peers were defined as trained "helpers" who could give advice based on training and their own experience, but the majority of apps did not provide any training for those providing support.

The medium through which peers connect with one another also varied between apps. Forums were more common than chatrooms; chatrooms were present in 8 apps, and forums in 19. Most chatrooms and forums were moderated in some way (one unmoderated chatroom and one unmoderated forum were identified). However, the type of moderation varied significantly from user-moderation (i.e., users are able to flag messages) to the presence of trained moderators. Fourteen apps (64%) provided the ability to send one-on-one messages with peers.

What are forums and chatrooms?

A **forum** is a space where discussions happen without users having to be online at the same time. Users can leave messages which can later be reviewed and responded to.

A **chatroom** allows users to communicate with other users in real time, typically through live text-based conversations.

In addition to peer support, some apps allowed users to connect to resources outside the app. Four apps (18%) had an option to connect to a therapist via the app and five apps (23%) could refer the user to a professional outside of the app. These resources were available more frequently in these peer chat apps compared to the previous review of meditation apps, where none of the apps reviewed provided a referral or connection to a therapist.

Feature Review: Terms of Service and Community Guidelines

Most apps reviewed stated that they will remove users who violate their terms, however it was not possible in this review to determine how frequently term violations occurred or how often users were removed. Below are examples.

Examples of Terms of Service

iPrevail: Prohibited actions include, but are not limited to: …Sharing, posting, or otherwise making available any content that Prevail Health deems to be harmful, threatening, unlawful, defamatory, infringing, abusive, inflammatory, harassing, vulgar, obscene, pornographic, fraudulent, invasive of privacy or publicity rights, hateful, or racially or ethnically objectionable.

TalkLife: We encourage you to express yourself but do not be abusive, offensive or swear excessively. Sexist, racist homophobic or transphobic posts are not allowed and will be removed. Sexually explicit posts, nudity and requests for dating will be removed-TalkLife is not the place for this. Posts describing or showing graphic violence or abuse can be upsetting for others and will be removed. Posts that encourage or condone illegal or criminal acts will be removed.

Tell us the bad, good and "meh" and share your difficult feelings but we don't allow talk of dangerous, unsafe or violent acts. These kind of posts can be very dangerous and triggering to others. Adding a trigger warning does not mean that these posts are ok.

Wakie: Every community member can report a violation if content (topic, comment or someone's profile picture) doesn't meet community expectations. Our moderators attentively handle each report and define a type of violation. Afterwards our algorithm concludes on the next step. If the content creator had no violations before, they would notified of a warning. But if they already had violations, it may lead to a ban.

Example of Community Guidelines

Do not insult, abuse, or harass staff, moderators or other members, either directly or indirectly. This includes, but is not limited to, offensive language, creating negative topics about a specific member, expressing hate speech or aggression toward groups, trolling, posting comments meant to embarrass the author of a topic, demanding social media or personal information, exposing private info, including personal chat screenshots, or impersonating other members.

User Experience Review

Two experts and one consumer examined the user experience of the peer chat apps. One app (TalkLife Campus) was not accessible to the reviewers, who are located outside the United States. Thus, reviews were obtained for 21 apps.

Table 3 presents user experience scores in the current peer chat app review and the past meditation app review. All scores are on a scale of 1-5, with a score of 4.00 indicating high-quality apps. Apps in the current review received lower scores from both experts and consumers than the meditation apps reviewed in the last report.

Table 3. Expert and Consumer User Experience Scores of Current and Past Market Surveillances

		Current Review Year: Peer Chat Apps (Y2 Q2)	Past Review: Meditation Apps (Y2 Q1)
Expert	Average	3.48	3.91
	Median	3.51	4.15
Consumer	Average	3.66	3.88
	Median	3.65	3.96

Both experts and the consumer gave high ratings for Sanvello. Experts also rated Therapeer and 365 Gratitude Journal highly. The consumer rated rTribe & Wisdo highly.

Reviewers generally noted that the apps were "simple" and "basic" in design, and didn't necessarily have the design features needed to keep users engaged. For example, apps did not always support "a natural start of a conversation, but invites users to message strangers off the bat."

Both the consumer and experts raised concerns that users may be exposed to conversations that are potentially "triggering," "inappropriate," or "unhelpful," particularly for "vulnerable people," and suggested that apps could be improved by better moderation.

Reviewers also noted that in order to reap benefits from the community features, **there needs to be an engaged community to message with, which was not always the case since many messages were unanswered**. The reviewers commented:

> *"[the app] is aimed at creating a support community, but such a community does not exist, so people leave lonely comments and no one reads them."*

> *"[the app] is still very new so it has not been able to build up its membership to be useful – I was not able to make any connections with any members. As there are no other features to this app, without a strong membership, it is not going to be very effective."*

One way to ensure community engagement is to have a dedicated taskforce of trained peers who regularly monitor chats and activity (an example of this is the strategies used by Riverside County's TakeMyHand). This would avoid having to rely on lay users, particularly when an app is in its infancy and still building a community.

Marketplace Data Review

The evaluation team gathered marketplace data for apps available on both iOS and Android platforms. In particular, the team reviewed (1) downloads; (2) retention; and (3) active users. Nineteen apps had marketplace data available on iOS and Android and were included below.

Downloads

Downloads refer to the number of new users downloading the app for the first time. If a user gets a new phone or re-downloads the app, it still counts as one download.

Table 4 shows overall downloads from June 2019 – June 2020 (combined across iOS and Android platforms) for both the current and the past market surveillance review. The apps reviewed in the current review had a wide range of downloads between the minimum and maximum numbers. As a result, this greatly distorted the average. Thus, the median (50,942 downloads) provided a better understanding of the number of users downloading peer chat apps reviewed over the past year.

Users downloaded the peer chat apps less than meditation apps. Commercial success and more widespread adoption of meditation apps considered in the past market surveillance compared to peer chat apps considered in the current review may explain this trend.

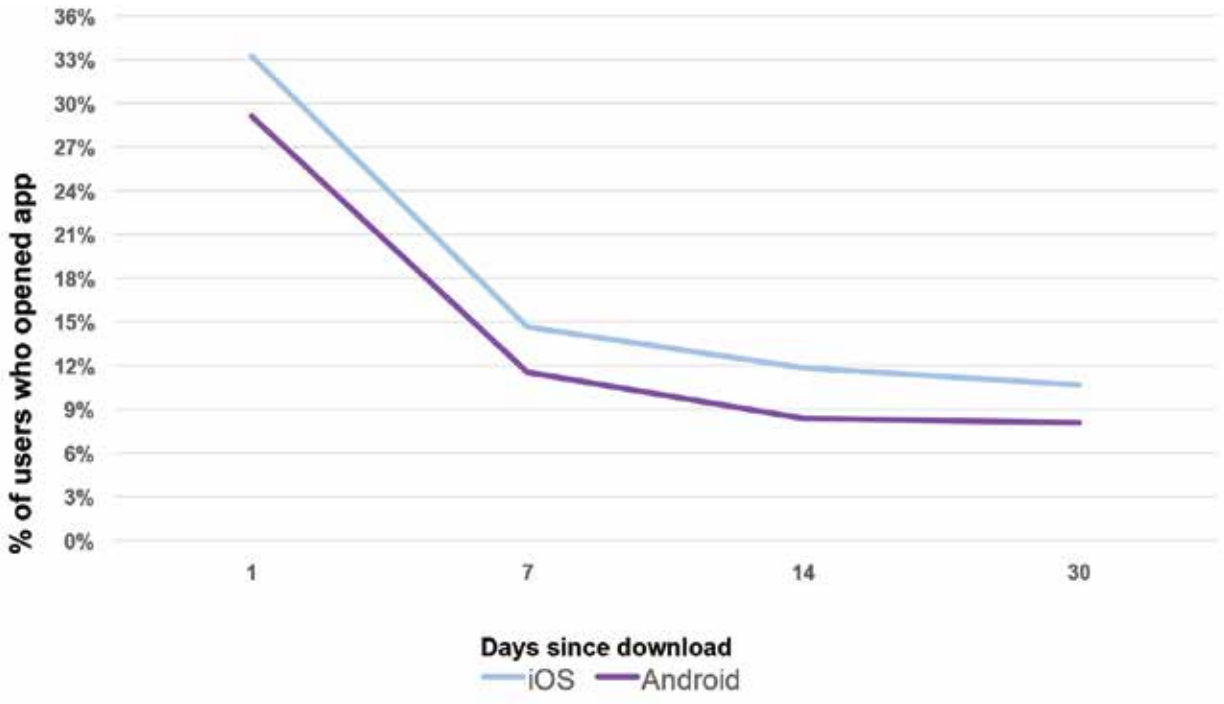
Table 4. Total Yearly Downloads of Current and Past Market Surveillances

	Current Review: Peer Chat Apps (Y2 Q2)	Past Review: Meditation Apps (Y2 Q1)
Average	128,534	1,540,819
Median	50,942	207,143
Minimum	301	152
Maximum	623,428	15,132,872

Retention

Retention describes sustained app use after the day of download (which is referred to as "Day 0"). **Figure 2** presents the overall retention trends for these apps from Day 1 to Day 30. Retention dropped considerably between Day 1 and Day 7. This trend aligned with previous research (Baumel, Muench, Edan, & Kane, 2019) and with the past review of meditation apps.

Figure 2: Overall Retention Across 30 Days (N = 14)



Active Users

Users are described as "active" if they opened the app at least once in a certain time frame. Daily active users refer to those users who opened the app at least once a day.

Table 5 shows the average number of daily active users over the past year. Median numbers best capture the data since the minimum and maximum have a wide range. Compared to meditation apps, peer chat apps have greatly fewer daily active users, which again may be attributed to the commercial success, popularity and adoption of meditation apps. As noted above, high volume or traffic is key to the success of peer chat apps, more so than apps which do not rely on engagement from other users in order to be beneficial for the individual.

Table 5: Daily Active Users over a Year in the Current and Past Market Surveillances

	Current Review: Peer Chat Apps (Y2 Q2)	Past Review: Meditation Apps (Y2 Q1)
Average	9,283	187,628
Median	1,778	16,393
Minimum	20	21
Maximum	49,067	1,848,034

COVID-19 App Discovery

Many Counties/Cities looked to publicly available free products that could be rapidly implemented to help their communities manage the challenges of COVID-19. The market surveillance team compiled a list of 10 free apps with added content or available content to help with the mental health impacts of COVID-19. **Appendix D** presents each reviewed app's platform, cost, intervention components, languages, population- and COVID-19-specific content, marketplace performance (i.e. downloads), and research evidence. Counties/Cities can use the review to understand the similarities and differences in well-established and popular free publicly available apps with COVID-19 content.

Learnings from Market Surveillance

The evaluation team reviewed peer chat apps and found:

- The market surveillance team has previously noted that the app marketplace changes frequently, with apps regularly being updated or becoming unavailable. This trend was pronounced in reviewing peer chat apps – an initial list of apps for review originally comprised 25 apps but three of these (12%) became inaccessible on the app store over the course of the review.
- Compared to meditation apps, peer chat apps had less robust accessibility features, with fewer customizable display options. This would make these apps inaccessible or hard to use for people, such as individuals with visual impairments.
- Peer chat components are not available offline. Users must have access to the Internet to engage with peer content, thus use may be challenging for users who do not have consistent internet access or have data plan restrictions.
- The vast majority of apps reviewed may not be suitable for certain target populations since they are only available in English and have little tailored content for those groups. Only two apps reviewed were available in languages other than English on Android.
- Most peer interactions are moderated, although it is not always clear by whom. Over half the apps allowed users to send one-on-one messages. One-on-one messages may undergo less moderation than publicly viewable messages.
- User experience scores for peer chat apps were lower than those for meditation apps, and reviewers raised concerns about moderation of content and the lack of community engagement on the platforms. Low community engagement might result in slow response times for users or outreaches going unanswered.
- As user experience reviewers noted, engagement and use of peer chat apps by large numbers of users is one of the keys to the success of these apps. Without an engaged, supportive community, messages from users will often go unanswered. Marketplace data show that active use, retention, and downloads of these apps are relatively low compared to commercially successful meditation apps.
- Sustained use of these apps was low, a pattern observed across multiple Help@Hand market surveillance reviews. Less than 10% of users open the after following Day 7.
- There are a range of free publicly available apps with content to help cope with the mental health impacts of COVID-19. Appendix D details these apps.
- As shown in expert reviews of 22 peer-chat apps, these apps in general are not well-developed, thus efforts to develop supportive peer technologies are much needed. This further highlights the need for work by Counties/Cities to develop novel and innovative technologies, i.e., TakeMyHand in Riverside County.

ENVIRONMENTAL SCAN

Other system-related factors that may affect Help@Hand are (1) general attitudes towards mental health (i.e., mental health stigma within communities); and (2) key media events related to mental health and/or Help@Hand specifically. An environmental scan monitors public perceptions of mental health documented through key media events. It aims to understand how international and local events (i.e., a celebrity opening up about their mental health struggles or a traumatic world event) may impact Help@Hand.

News stories based on keywords related to Help@Hand continue to be monitored and collected. Analysis of these news stories has not started because of limited staffing to support the environmental scan.

COLLABORATIVE PROCESS EVALUATION

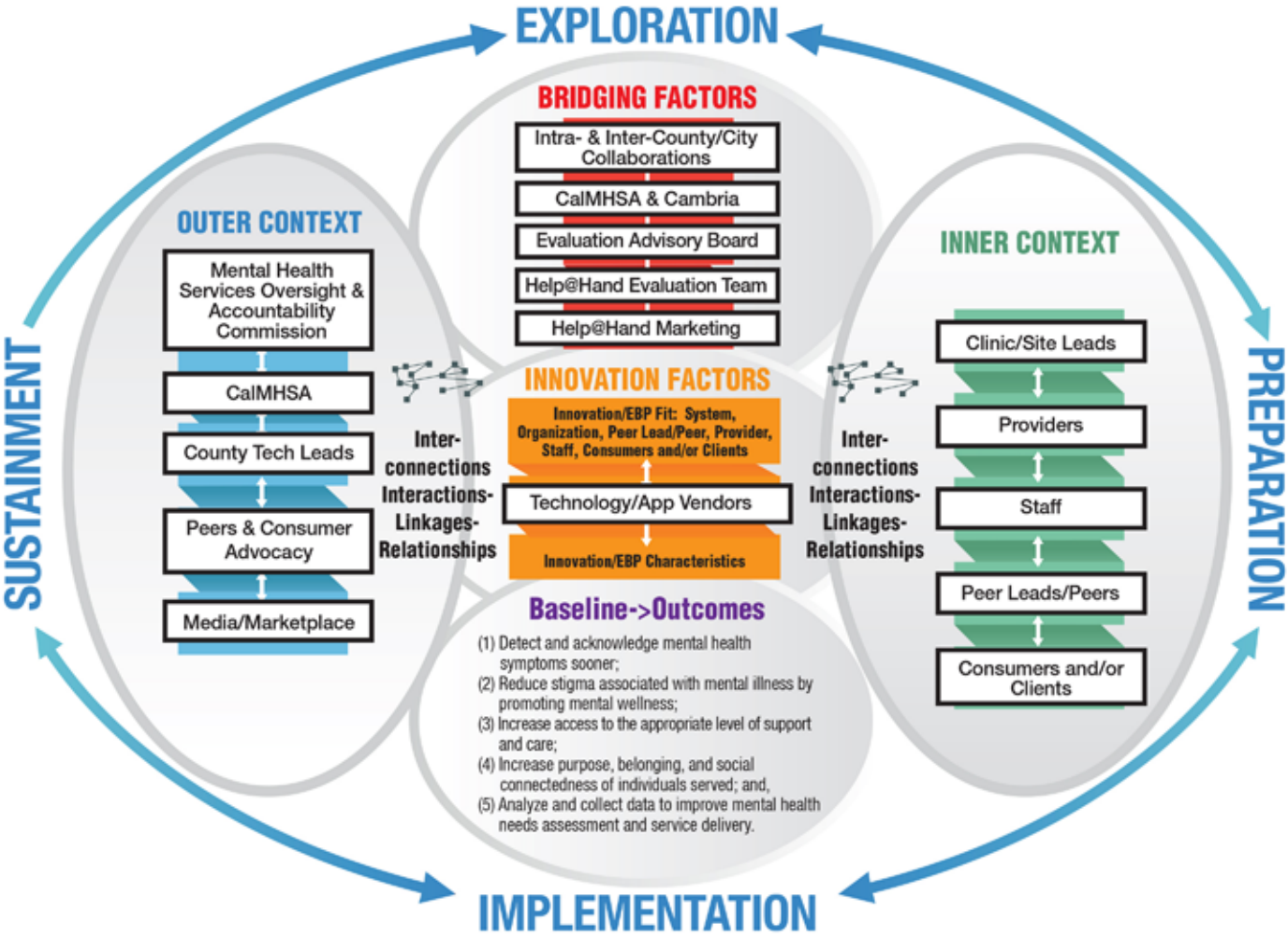
The progress and success of Help@Hand is also influenced by the processes, interactions and collaboration across the Help@Hand Collaborative members and supporting stakeholder groups. Examples of collaboration are the County/City-led workgroups shown in **Table 6**.

Table 6. County/City-Led Workgroups

WORKGROUP NAME	WORKGROUP MEMBERS	PURPOSE	INITIATION DATE	NUMBER OF CONVENINGS TO DATE	CURRENT STATUS
Roadmap Workgroup	Joined 6/2019: Orange Los Angeles Kern Joined 8/2019: Modoc San Mateo Santa Barbara	Identify and operationalize key strategic project priorities	June 2019	12	Workgroup did not meet during Quarter 2, 2020 due to county capacity as a result of COVID-19. Current status: CalMHSA updated roadmap tasks in progress and completed, re-convene workgroup before next Virtual Collaborative meeting.
Linguistic and Cultural Adaptation Workgroup	Orange Los Angeles San Mateo Riverside Santa Barbara Marin	Ensure linguistic and cultural sensitivity of Help@Hand technologies	February 2020	2	Workgroup last met March 2020. Additional meetings have been on hold due to county capacity as a result of COVID-19. Current status: Workgroup members reviewing and de–termining county/city specific focus and goals for linguistic and cultural adaptation. Next workgroup meeting TBD.
Risk and Liability	San Mateo CalMHSA staff Carl Bonacci, SME David Young, SME	Identify principals, that allow CalMHSA and participating counties to make decisions re–garding the use of digital tools for the purpose of providing Mental Health services through innova–tive technologies.	June 2019	Approximately 12, with additional work to finalize the DBHQ completed after workgroup work concluded	This work is complete. Work–group efforts resulted in the production of the Risk and Lia–bility worksheet, later renamed as Digital Behavioral Health Questionnaire. Cities/counties are actively using the DBHQ to help inform their pilot planning and implementations.

The collaborative process evaluation serves to understand the factors that facilitate or impede Help@Hand at the system and organizational levels. The evaluation team developed a collaborative process evaluation based on the Exploration, Preparation, Implementation, Sustainment Framework (EPIS) (Aarons, Hurlburt & Horwitz, 2011; Moullin, Dickson, Stadnick, Rabin & Aarons, 2019). The EPIS Framework highlights key phases of the implementation process and describes various factors within and between the outer context (i.e., system and policy levels) and the inner context (i.e., organizational, provider, and consumer levels). **Figure 3** shows the EPIS framework applied to Help@Hand. The primary focus of the collaborative process evaluation includes the outer context, bridging factors, and innovation factors. The implementation evaluation described in the next chapter explores the inner context.

Figure 3. EPIS Framework Applied to Help@Hand



The evaluation team developed interview guides and surveys for the collaborative process evaluation in Year 1 and updated the interview guide this quarter to reflect changes in Help@Hand. However, the Collaborative requested a pause on conducting interviews and surveys since October 2019. Discussions on changing the Help@Hand evaluation's scope, including whether to proceed with the collaborative process evaluation, occurred this quarter. As such, no data was collected and there are no learnings/findings from the collaborative process evaluation this quarter.

2 COUNTY/CITY AND SITE-LEVEL IMPLEMENTATION EVALUATION

Key Points

- The Help@Hand evaluation team worked with Orange and Riverside Counties to evaluate implementation of Mindstrong in Orange County and Take My Hand in Riverside County. Evaluation included interviews with clinicians in Orange County and Peer Operators in Riverside County.
- The evaluation team tracked Peer Program activities through 13 interviews across 12 Counties/Cities this quarter. Interviews were conducted with Peer Leads and Tech Leads for those Counties/Cities with no Peer Lead

OVERVIEW

Examining the facilitators and barriers and perspectives from key stakeholders of implementing Help@Hand technologies within a County/City can provide insights on project successes and challenges. This chapter focuses on how site-level factors and Peers may influence the implementation of Help@Hand technologies within Counties/Cities. It presents evaluation activities and learnings as follows:

- **Pilot Evaluation: County/City and Site-Level Implementation**
  - Orange County's Mindstrong Initiative: Pre-Implementation Evaluation
  - Riverside County's Take My Hand: Implementation Evaluation
- **Peer Program Evaluation**

PILOT EVALUATION: COUNTY/CITY AND SITE-LEVEL IMPLEMENTATION

Pilot evaluation activities assessing County/City and site-level implementation varied by County/City since each County/City was in a different phase of implementation. In this quarter, pre-implementation interviews were conducted in Orange County to examine the early implementation (pre-implementation) efforts of Orange County's Mindstrong initiative. In addition, an evaluation of Riverside County's Take My Hand platform was also conducted.

Orange County's Mindstrong Initiative: Pre-Implementation Evaluation

Orange County began planning their Mindstrong implementation in June 2018. Orange County, in partnership with Mindstrong, UCI Health Psychiatry Services, and other stakeholders, launched their initiative in May 2020. Early implementation involved two providers referring their eligible clients to connect with a behavioral health clinician for therapy and 24/7 support via the Mindstrong app for free. The first client was referred on May 14, 2020.

Evaluation Methods

The Help@Hand evaluation team conducted semi-structured interviews in June 2020 with the two referring providers. The purpose of the interviews was to: 1) understand the clinical services received by UCI Health Psychiatry Services prior to the use of Mindstrong; 2) identify early learnings from the initial Mindstrong implementation; and 3) elicit strategies to facilitate the Mindstrong implementation moving forward.

Both interviewees are faculty in the UCI School of Medicine and psychiatrists for UCI Health Psychiatry Services, where they have worked for several years. Each interview lasted approximately 30 minutes. The interview guide was adapted from previous Help@Hand evaluation guides and included a combination of questions on leadership, general implementation, and COVID-19.

Sample Interview Questions for Orange County's Mindstrong Initiative:

"How confident are you that you will be able to use Mindstrong?"

"How do you think the individuals served by your organization will respond to Mindstrong?"

"How has COVID-19 impacted you and your clinic's plans to implement Mindstrong?"

"Who are the key influential individuals to get on board with this implementation of Mindstrong?"

The Help@Hand evaluation team is in the process of analyzing the interview data. A "Learning Update," which synthesizes information from the interviews and provides recommendations for scale-up, will be shared with Orange County for feedback in the next quarter. Interview findings and learnings will also be presented in the next quarter report.

Riverside County's Take My Hand: Implementation Evaluation

In response to not finding an existing technology that fit their County-specific needs, Riverside County developed its own technology product, Take My Hand. Through the Take My Hand website, County-employed Peer Operators provide wellness support to online users. The online peer support platform is based on the Peer Support Model, an evidenced-based practice where people who have been successful in their recovery help others with similar "lived experiences" improve their well-being (Mead, 2003; Mead S., & MacNeil C., 2006). Take My Hand was launched on April 17, 2020 and piloted through June 30, 2020.

Evaluation Methods

The Help@Hand evaluation team collaborated with Riverside's internal evaluation team to assess the implementation of Take My Hand. Riverside County developed a survey that they sent to the 12 Peer Operators and 4 clinicians who worked on Take My Hand. Following the completion of the surveys, participants were invited to schedule a 30-minute interview with the Help@Hand evaluation team. The semi-structured interviews sought to understand the perspectives and experiences of the Peer Operators and clinicians who worked on the Take My Hand platform.

Only 11 of the Peer Operators responded and completed interviews. Interviews were transcribed by a professional transcription company coordinated by the Help@Hand evaluation team and then sent to Riverside County for analysis. Riverside County will combine interview analysis with data from their surveys, website analytics, and marketing in order to create recommendations for the County moving forward. Riverside County will consult with the Help@Hand evaluation team as they synthesize their findings. Findings and learnings will be presented in the next quarter report.

Sample Interview Questions for Riverside County's Take My Hand:

"What features of Take My Hand did you like?"

"Did you come across any barriers to using Take my Hand, either experienced by the individuals with whom you chatted or your own experience?"

"How have the people who you have chatted with responded to Take My Hand?

"What training or experience did you find most helpful in your ability to use Take my Hand as a Peer Operator?"

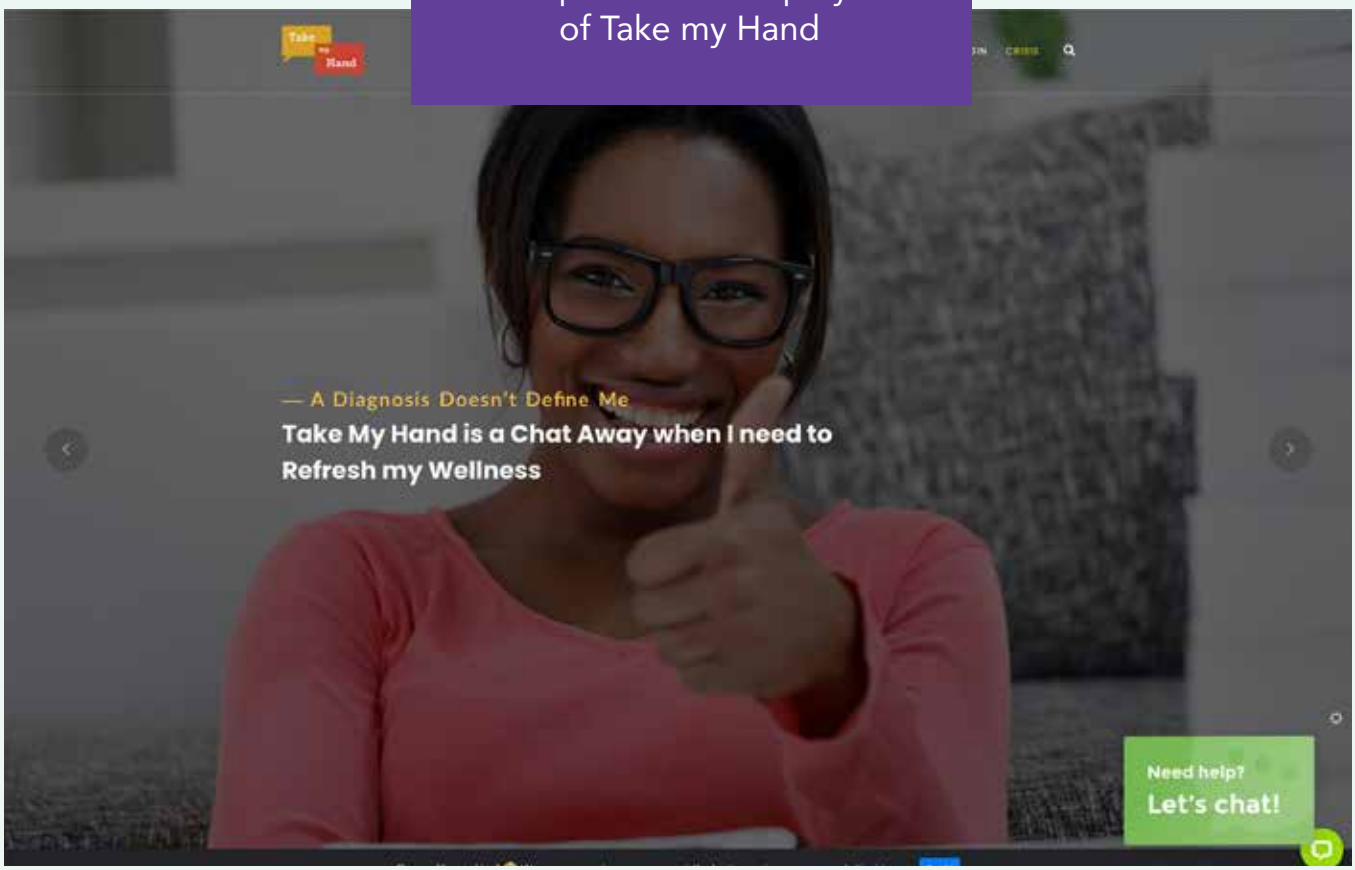
PEER PROGRAM EVALUATION

The evaluation team continued to track the Peer Program activities across the Collaborative through quarterly interviews with each Peer Lead or Tech Lead for those Counties/Cities with no Peer Lead. During this quarter, 13 interviews were conducted across 12 Counties/Cities. Of these interviews, 11 were conducted with Peer Leads and 2 with Tech Leads. The interviewees represented Kern, Los Angeles, Marin Modoc, Monterey, Orange, Riverside, San Mateo, Santa Barbara, and Tehama Counties as well as City of Berkeley and Tri-City.

These interviews have been summarized and are in the process of being content-analyzed for the purpose of identifying cross-collaborative themes and lessons learned. Findings and learnings from this analysis will be reported in the next quarter report.

SPOTLIGHT: RIVERSIDE COUNTY

Development and Deployment of Take my Hand



Discovery of a Need

Peer support is an essential part of mental wellness and recovery. Riverside University Health System-Behavioral Health (RUHS-BH) has a strong Peer workforce placing them in a unique position to provide substantial support networks for those experiencing isolation, stress, and other behavioral health issues. In April 2019, RUHS-BH began to explore apps to pilot for Help@Hand and determined it was important to have an app that incorporated with their already established Peer workforce. **Unable to find an app that fit their needs, the team decided to develop a platform of their own that utilized their Peer workforce.** The RUHS-BH Help@Hand team recalled:

> *"Consistent disappointment of over 100 apps tested, due to the absence of a live person on the other side of the 'Peer Support' function of a tested app. The use of a 'bot' or 'AI' (artificial intelligence) component proved, through that testing, that it was not 'real peer support' and lacked the intuition of a Peer Support Specialist, the language or the nuance of coaching that Certified Peer Support Specialists do in an interaction with a person they serve."- RUHS-BH Help@Hand team*

This spotlight was developed in partnership with support from members of the Riverside University Health System-Behavioral Health (RUHS-BH) Help@Hand Team: Maria Martha Moreno (Help@Hand Tech Lead), Shannon McCleerey-Hooper (Consumer Affairs Program Manager), Pamela Norton (Senior Peer Support Specialist), Dakota Brown (Peer Support Specialist), Melissa Vasquez (Peer Support Specialist), Mariah Andrews (Clinical Supervisor), Rick Wright (Take my Hand Application Developer), Ursula Lewis (Administrative Service Analyst), Suzanna Williamson (Supervising Research Specialist with RUHS-BH's Evaluation Unit), Christy Mota (Research Specialist with RUHS-BH's Evaluation Unit), and Brandon Jacob (Deputy Director Research, Quality & Access).

"Take my Hand" was developed to meet the needs of Riverside's community, while fully embracing the Peer Support model. Critical to the Peer support model is the Peer Support Specialist, who:

> *"… engages with the person receiving services one-on-one or in a group setting. The person receiving services has the opportunity to experience what it's like to walk side-by-side with a person who has 'been there', while learning new tools and practicing new skills in moving through challenges."- Take my Hand Website*

As RUHS-BH Help@Hand team recalled, they called the platform "Take my Hand" because:

> *"The Tech Team called it 'Take my Hand', which was immediately embraced by the Peer Support Team as an example of the recovery concept of a 'Welcoming Environment' for the end user."- RUHS-BH Help@Hand team*

RUHS-BH Develops Take my Hand

The RUHS-BH Help@Hand team presented Take my Hand to their internal leadership on July 27, 2019 and received overwhelming support. Executive management gave the go-ahead to continue working on the platform.

After obtaining leadership approval, the team shared Take my Hand with the Help@Hand Collaborative in Sacramento on October 24, 2019. The Collaborative received the platform well and offered valuable feedback.

With the support of both RUHS-BH leadership and the Help@Hand Collaborative, the RUHS-BH Help@Hand team continued developing Take my Hand.

COVID-19's Impact in Riverside

In March 2020, COVID-19 had a tremendous impact on Riverside County. RUHS-BH leadership needed to find a safe alternative to the growing strain being placed on 911 and 211 crisis call centers. Take my Hand was identified as a possible solution:

> *"… to assist community members to problem-solve new emotional challenges, provide comfort and support to reduce symptoms of anxiety, depression or the natural fears that come from things unknown [Like COVID-19]." – Shannon McCleerey-Hooper, Consumer Affairs Manager*

As such, leadership put out an urgent directive calling for Take my Hand to be up and running by April 17, 2020.

Rapid Deployment of Take my Hand in Response to COVID-19

In order to meet the urgent directive, the RUHS-BH Help@Hand team put out a "call to action" within their agency. Dakota Brown (line staff Peer Support Specialist) quickly created the first training curriculum for Take my Hand with feedback and guidance from Pamela Norton (Senior Peer Specialist). Canned responses, protocols for crisis transfers, and HelpLine information were also developed for Peer Operators to use during chats.

A total of 12 Peer Support Specialists from various departments within Riverside County volunteered their time and expertise to support the public as well as RUHS-BH clients. Eleven of the Peer Support Specialist were "borrowed" from programs other than Help@Hand for a 10-week period. They operated the chats, while they worked from home in accordance with the COVID-19 State Stay-at-Home Orders. They were:

> *"… excited to participate and utilize their peer support skills to assist community members experiencing anxieties of the pandemic." – RUHS-BH Help@Hand team*

Additionally, eight clinicians employed by RUHS-BH volunteered to be on-call and receive crisis transfers. Riverside County defines crisis transfers as "urgency based on visitor identification of immediate urge to harm self or other, [or] in immediate danger of harm from another.

Take my Hand's 10-Week Testing Phase

Take my Hand was successfully launched at 8am PST on April 17,2020 for a ten-week test phase. It was offered 24/7 for the first 9 weeks by providing four shifts in a 24-hour period with Peer Support Specialists and on-call clinicians.

The RUHS-BH Help@Hand team worked with the Help@Hand Collaborative and RUHS-BH's internal evaluation team to consider the initial deployment as a "test phase." The test phase assessed accessibility, effectiveness of outreach, ease of use, peer-to-peer engagement, experience of Peer Support Specialists using chats, and other aspects.

Peer Operators Make Important Discoveries in the Test Phase

During the test phase, the Take my Hand website was visited 158,216 times with 5,830 unique visitors to the website. During week nine, the majority of the Peer Operators were recalled back to their departments and the hours of operation for Take my Hand were reduced to 8:00am-10:30pm, Monday through Friday until the end of the test phase on June 30, 2020.

During the ten-week test phase, many discoveries were made by the Peer Operators. Discoveries included:

"Many visitors leave the website when asked to answer questions before being placed in a chat. This can create feelings of unease and frustration for Peer Operators working the chat, when chat traffic is slow"- Take my Hand Peer Operator

"Some Peer Operators, who came to the chat after working in the service system for many years discovered they were in need of review of basic peer support skills learned early on in their Peer Support careers." – Take my Hand Peer Operator

"All in all, this process of rapid deployment of the Take my Hand was a huge learning experience for all involved and Riverside University Health System-Behavioral Health is proud to be at the forefront of innovation in terms of creating new ways to reach and support the people of our community." - RUHS-BH Help@Hand team

Future Directions for Take my Hand

In order to evaluate the success of Take my Hand and inform future Take my Hand decisions, data was gathered during the 10-week test phase by RUHS-BH's internal evaluation team and the Help@Hand evaluation team. The evaluation consisted of: web-analytics from the Take my Hand website; surveys with the Peer Operators and on-call clinicians; interviews with the Peer Operators; and post-chat surveys with visitors. Analysis of these sources is currently underway.

3 USER EXPERIENCE AND TECHNOLOGY EVALUATION

Key Points

- San Mateo, Marin, and Riverside Counties worked with CalMHSA and the Help@Hand evaluation team to explore potential technologies to pilot. Surveys and/or focus group protocols were developed to support exploration of each technology considered. Marin County conducted focus groups with members of their target population to gather feedback from potential users and inform selection of appropriate technologies to pilot.
- Tehama County and Tri-City identified potential apps to pilot in their target populations. With support from CalMHSA and the evaluation team, Tehama County and Tri-City began planning their pilots. This involved developing their pilot proposal and evaluation plans as well as identifying and responding to potential risks and opportunities.
- Orange County launched their Mindstrong implementation this quarter with support from CalMHSA, the evaluation team, and various other experts. Key activities involved developing consent form and recruitment processes in light of COVID-19; planning evaluation activities, such as collecting data from Mindstrong and electronic medical records as well as user surveys and interviews; and gathering data from piloting providers.
- Los Angeles and Riverside Counties respectively launched Headspace and Take my Hand (a platform developed by Riverside County). The Rapid Response framework allowed these technologies to quickly be deployed to support communities during COVD-19. Evaluation data was also collected to inform further implementations of these technologies.
- A survey of community college students' mental health needs was conducted and may help inform the selection of Help@Hand apps for this target audience. Preliminary findings suggest that apps that address stress, depression, and anxiety; allow students to talk with other people to get/give support (including professional services); work through negative emotions and thoughts; and/or identify and recognize symptoms may be suited for college students.

OVERVIEW

The user experience and technology evaluation examines the user[8] and non-user[9] experiences with technologies. This chapter focuses on stakeholder feedback for Help@Hand technology exploration and selection as well as factors associated with adoption and continued use of Help@Hand:

- **Technology Exploration, Selection, and User Pilot Evaluation**
  - Technology Exploration and Selection
  - User Pilot Evaluation
  - Learnings from the Technology Exploration, Selection, and User Pilot Evaluation
- **College Student Survey**
  - Los Angeles County and El Camino College
    - Preliminary Findings
    - Preliminary Learnings from the College Student Survey

TECHNOLOGY EXPLORATION, SELECTION, AND USER PILOT EVALUATION

User experience and technology evaluation efforts this quarter included working closely with the Help@Hand Collaborative to explore potential apps and plan user evaluations for upcoming pilots. **Table 7** provides an overview of the current stage, technology considered, and evaluation support given to Counties/Cities engaged with the Help@Hand evaluation team in Quarter 2. Findings are not presented since data was not collected and analyzed this quarter.

[8] A user is defined as an individual who uses a computer technology or network such as apps.
[9] A non-user is defined as an individual who is aware of the app but chooses one of the following: (1) not to download the app (these individuals are "never triers"); (2) download the app but not register (these individuals are "non-registers"); or (3) download the app and register but do not have any activity with the app (these individuals are "non-adopters").

Table 7. Counties/Cities Engaged with the Help@Hand Evaluation Team in Quarter 2

County/ City	Current Stage	Technology	Evaluation Support
Marin	Technology Exploration and Selection	Exploring Uniper and myStrength	• Shared and adapted technology exploration user surveys and focus group protocols • Explored Happify (no longer being considered), Uniper, and myStrength to adapt instruments • Provided guidance and technical assistance during user testing • Analyzed survey and focus group data
Orange	Early Implementation	Mindstrong	• Collaborated with Orange County to build evaluation plan and address potential issues • Began development of pre, post, and interim user surveys and interview protocols • Created consent forms and recruitment materials • Submitted application to UCI's IRB to begin data collection • Provided expert input and support to help identify potential data
Riverside	Rapid COVID-19 Response	Take my Hand	• Provided critical feedback on post-experience user survey • Provided critical feedback on Peer Operator and clinician survey and interview guide • Supported Peer Operator data collection • Provided guidance and evaluation assistance during implementation
Riverside	Technology Exploration and Selection	Exploring various technologies (in addition to Take my Hand)	• Shared technology exploration user surveys and focus group protocol
San Mateo	Technology Exploration and Selection	Exploring various technologies	• Provided recommendations on how to effectively review apps • Shared and adapted technology exploration user surveys
San Mateo	Rapid COVID-19 Response	Headspace	
Tehama	Pilot Planning	myStrength	• Collaborated with Tehama County to build evaluation plan and address potential issues • Began tailoring user surveys, interview guides, and focus group protocols • Provided feedback on Digital Mental Health Literacy materials
Los Angeles	Rapid COVID-19 Response	Headspace	• Provided expert input and recommendations on Headspace dashboard
Tri-City	Pilot Planning	Wysa	• Collaborated with Tri-City to build evaluation plan and address potential issues • Began tailoring user surveys and focus group protocols • Explored Wysa to adapt instruments • Provided recommendations for Wysa dashboard data

Technology Exploration and Selection

San Mateo, Marin, and Riverside Counties explored potential technologies to inform which to select for their pilot. Exploration involved utilizing technology exploration surveys and/or focus group protocols to gather and compare feedback from potential users across technologies under consideration for pilots. This feedback should inform the selection of technologies for pilots.

San Mateo County

Last quarter San Mateo County considered Remente for their transitional aged youth (TAY) population and Happify for their older adult population. However, TAY feedback revealed that Remente did not meet their needs. Though Remente was open to adding features based on youth suggestions, such as specific mental health or school-related modules, it was not expected to have the desired features in time for a pilot. In addition, Happify announced that they were no longer available for Help@Hand pilots. San Mateo, therefore, spent this quarter examining other potential apps for their TAY and older adult populations.

CalMHSA and the Help@Hand evaluation team provided insights on how to effectively review apps during technology exploration. Generic technology exploration user survey instruments were shared with San Mateo County. Instruments were tailored and formatted into online surveys based on their learning goals and target populations. San Mateo will begin to test apps with their TAY and older adult populations in the next quarter.

Marin County

Last quarter Marin County reviewed apps from the most recent Help@Hand Request for Statement of Qualifications (RFSQ) and determined that myStrength, Uniper, and Happify might be most appropriate for their isolated, older adult population.

Marin County worked closely with CalMHSA and the Help@Hand evaluation team to develop a process that would support virtual technology exploration due to the impact of COVID-19. The process involved 1) completing a Participation Agreement and demographic survey; 2) exploring the technology over 7 days; 3) completing a technology experience survey; and 4) participating in a virtual focus group. The evaluation team reviewed myStrength, Uniper web- and TV-version, and Happify in order to tailor generic surveys and focus group protocols for each technology.[10] Surveys were formatted to online versions.

With guidance and support from CalMHSA and the Help@Hand evaluation, Marin County engaged twelve older adults in myStrength and Uniper user testing through focus groups and surveys from June 1-July 20, 2020. Focus group and survey data will be analyzed during the next quarter. More information about Marin County's effort can be found in the Spotlight on page 51.

Riverside County

In addition to launching their own platform described below, Riverside County began exploring other potential apps to pilot with their target populations. These included: 1) a custom development of an app for their deaf and hard of hearing population; and 2) other apps in the publicly available marketplace that were identified in the recent Help@Hand RFSQ.

This quarter CalMHSA and the Help@Hand evaluation team began to provide insight and support as Riverside County considered these potential apps. The evaluation team also began working with Riverside County to develop technology exploration user surveys and focus group protocol.

User Evaluation

Tehama County, Tri-City, Orange County, Los Angeles County, and Riverside County worked on planning a pilot and/or launched a product this quarter.

[10] Happify was removed from consideration because they are no longer available for pilots.

Tehama County

Tehama County plans to pilot myStrength among three target populations: 1) existing behavioral health consumers; 2) individuals experiencing homelessness; and 3) the geographically isolated. MyStrength was selected since it does not collect a lot of user data and was thought to be a good fit for Tehama County's target populations that may be hesitant to try new technologies. The County worked with CalMHSA and the Help@Hand evaluation team to develop their pilot and pilot evaluation plans, which will be presented to Help@Hand Leadership for approval next quarter.

For the Tehama County pilot, Peers will recruit and support participants from the three target populations. Digital Mental Health Literacy (DMHL) materials are critical for these efforts. This quarter Tehama County, CalMHSA, and the evaluation team reviewed and adapted DMHL materials that may be well-received by the target population and support their adoption of myStrength.

Additional facilitators and barriers related to implementing myStrength, such as Wifi, charging stations, digital literacy, and available app data, were also identified. Due to anticipated data collection constraints (i.e., users' unwillingness and discomfort disclosing personal information on surveys), Tehama County will also conduct interviews and focus groups with users in order to fully understand the user experience of myStrength among the populations. The evaluation team is working with Tehama County to tailor user surveys, interview guides, and focus group protocols.

Tri-City

Tri-City plans to pilot Wysa with TAY that are currently engaged with programs offered through Tri-City's wellness centers. Tri-City will also include four clinicians in their pilots to learn how Wysa complements their work. Wysa was selected after peers in Tri-City reviewed various apps and provided positive feedback on the app.

This quarter Tri-City began contract negotiations with Wysa. Experts were consulted to aid in Tri-City's contract negotiations, including the evaluation team who provided recommendations for Wysa's data dashboard.

Tri-City also developed their pilot proposal and evaluation plan with support from CalMHSA and the Help@Hand evaluation team. The pilot proposal and evaluation plan will be presented to Help@Hand Leadership next quarter. Peer-reviewed publications and an analytic report on Wysa informed Tri-City's benchmarks. The evaluation team is currently exploring Wysa to adapt user surveys and focus group questions for data collection that will occur at multiple timepoints throughout the pilot.

Orange County

Orange County launched Mindstrong with two providers from UCI Health Psychiatry Services this quarter. The providers referred their eligible clients to use the Mindstrong app for free in order to connect with a behavioral health clinician for therapy and 24/7 support.

Expert input and extensive support were provided by the Tech Leads of the Health Care Agency, CalMHSA/Cambria project management, Help@Hand evaluation, and Mindstrong to faciliate the identification of potential data sources within Mindstrong and develop the infrastructure to gather this data. Similar input and support were given to collect electronic medical record (EMR) data from UCI Health Psychiatry Services.

In addition to pre-implementation evaluation (described in the Pilot Evaluation County/City and Site-Level Implementation chapter), the Help@Hand evaluation team began to tailor user surveys and develop interview protocols to be conducted with users and non-users at various timepoints (i.e., pre, post, and interim surveys and interviews). Consent documents and data collection instruments developed specifically for the purpose of the evaluation were submitted to UCI's Institutional Review Board (IRB) for approval. More information about Orange County's early implementation can be found in the Spotlight on page 15.

Los Angeles County

The impact of COVID-19 required Counties/Cities in the Help@Hand Collaborative to respond in new ways in order to support their communities. Help@Hand Leadership offered flexibility to allow Counties/Cities to implement an

accelerated COVID-19 response and make technologies available to community members as quickly as possible.

Los Angeles presented three pilot proposals (Uniper for older adults; CredibleMind for isolated populations at higher risk of serious complications from COVID-19; and Headspace for adult cognitive behavioral health (CBT) clients and individuals seeking Peer Resource Center support) to Help@Hand Leadership for approval. The three pilot proposals were approved in April. Due to the onset of COVID-19, Los Angeles paused their pilot launches in order to focus on their Headspace Rapid Response. The effort allowed quick implementation of technologies to help communities during the COVID-19 pandemic. The County partnered with Headspace to offer free Headspace Plus subscriptions to all Los Angeles County residents beginning in April 2020.

Los Angeles County, with input from CalMHSA and the Help@Hand evaluation team, worked with Headspace to develop a dashboard to evaluate Los Angeles County's Headspace Rapid Response effort. The dashboard included: the number of members added, active sessions, and the types of sessions that are accessed most.

San Mateo County is planning to launch a similar Headspace COVID response efforts next quarter.

Riverside County

In response to COVID-19, Riverside County launched Take my Hand, a peer-chat app developed by Riverside County. Take my Hand was deployed to Riverside County residents from April 17-June 30, 2020. Peer Support Specialists operated chats and on-call clinicians were available to support individuals whose chats indicated they were in crisis.

In addition to supporting Riverside County with their implementation evaluation (described in the Pilot Evaluation County/City and Site-Level Implementation chapter), the Help@Hand evaluation team provided generic user surveys that Riverside County adapted to gather feedback from Take my Hand users. More information about Riverside County's Rapid COVID-19 Response can be found in the Spotlight on page 35.

Learnings from the Technology Exploration, Selection, and User Pilot Evaluation

The Help@Hand evaluation team worked with Counties/Cities to develop their technology exploration and selection as well as user pilot evaluations. Key learnings include:

- Counties/Cities can learn a lot from their experiences during the technology exploration and selection stage in order to improve their own processes – both for ongoing and future technology exploration and selection as well as their pilots. When these learnings are shared across the Collaborative, other Counties/Cities can save time and effort by leveraging the successes and mitigating the challenges of other Counties/Cities in order to inform their own processes and procedures.
- An individual County/City can gather helpful feedback from potential users during the technology exploration and selection stage by using a systemic approach to data collection and standardized data collection instruments. Feedback gathered can inform the County/City's pilot learning goals and identify which app to pilot. The feedback can also be useful for other Counties/Cities who have a similar target audience or who are interested in the same technologies.
- While standardized measures are useful and employed across the Help@Hand Collaborative, pilot plans, target populations, and technologies vary widely across the Collaborative. As a result, user instruments must be tailored to each County/City's goals, target audiences, chosen technologies, and implementation approach.

COLLEGE STUDENT SURVEY

The Help@Hand evaluation team developed a survey of college students' mental health needs since Help@Hand Counties/Cities identified college-aged students as an important target population.

The survey can provide Counties/Cities access to timely data and feedback that identify the most important needs and desires of a community, which in turn may inform implementation planning and decision making. As shown in **Figure 4**, the college student survey may help identify: 1) factors likely to influence adoption of Help@Hand apps; 2) current apps, technologies, and resources used in the community; 3) current mental health needs and beliefs of the target population; 4) baselines for outcome and mental health literacy measures; and 5) insights for recruitment strategies. Findings and learnings from the survey may inform planning and decision making related to, but not limited to, matching a target audience's need to Help@Hand apps.

Figure 4. Purpose of College Student Survey

Los Angeles County Department of Mental Health and El Camino College Needs Assessment

Los Angeles County expressed interest in understanding unmet mental health needs among community college students, how apps may address these unmet needs, and how to engage community college students, including those not currently using such technology. Los Angeles County partnered with El Camino College and the Help@Hand evaluation team to plan and conduct a survey with students at El Camino College.

The survey was distributed electronically from April 16 – June 30, 2020 to a random sample of 5,000 students at El Camino College. Sampling was done proportionate to demographic figures (gender and race) for California community colleges.[11] Participants received a $10 Amazon gift card for completing the survey.

Preliminary Findings

Of the 574 participants who started the survey, 500 completed the survey (response rate 11%, 574/5000). Please note that the data in this section only represent a selection of the data collected. A full report will be forthcoming once full data analyses are complete.

It is also important to note that data was collected during COVID-19, which may influence the results. Questions about COVID-19 were asked in order to gauge changes resulting from the pandemic. Twenty-one percent (21%) of respondents knew someone who had been diagnosed with COVID-19 or had been diagnosed themselves. Forty-two percent (42%) of respondents either had their hours reduced or lost their job as a result of COVID-19.

[11] The latest demographic figures for California community colleges were extracted from https://datamart.cccco.edu/Default.aspx

Demographics

Table 8 shows demographic information. Survey respondents had a mean age of 23.8 (SD = 8.0) years, 63% identified as women, and 78% identified as heterosexual or straight. Twenty-seven percent (27%) identified as White and 24% identified as Hispanic/Latinx. In terms of ethnicity, 37% identified as Mexican/Mexican-American/Chicano.

Seventeen percent (17%) reported their annual household income as less than US $10,000. The primary language used was English for 62% respondents and Spanish for 27% of respondents. Very few (2%) experienced homelessness, and 9% of respondents indicated they had a disability.

Table 8. Demographics of El Camino College Student Survey Respondents (N=500)

Demographics	Mean (SD)
Age	23.8 (8.0)
Demographics	**N (%)[12]**
Gender	
Male	171 (34%)
Female	314 (63%)
Race	
White	137 (27%)
Hispanic/Latino/a/x	119 (24%)
Asian	66 (13%)
More than one race	44 (9%)
Black or African American	32 (6%)
American Indian or Alaska Native	3 (1%)
Native Hawaiian or other Pacific Islander	3 (1%)
Ethnicity	
Mexican/Mexican-American/Chicano	183 (37%)
More than one ethnicity	55 (11%)
European	46 (9%)
Central American	37 (7%)
African	18 (4%)
Filipino	15 (3%)
Middle Eastern	13 (3%)
South American	12 (2%)
Chinese	10 (2%)
Eastern European	10 (2%)
Japanese	9 (2%)
Vietnamese	9 (2%)
Asian Indian/South Asian	6 (1%)
Korean	3 (1%)

Demographics	N (%)[12]
Language	
English	310 (62%)
Spanish	135 (27%)
Vietnamese	7 (1%)
Arabic	6 (1%)
Mandarin	4 (1%)
Russian	3 (1%)
Sexual orientation	
Heterosexual or Straight	391 (78%)
Bisexual	39 (8%)
Questioning or unsure of sexual orientation	18 (4%)
Homeless	
Yes	12 (2%)
No	472 (94%)
Household income	
<$10,000	87 (17%)
$10,0000 – $29,999	131 (26%)
$30,000 - $49,999	59 (12%)
$50,000 - $89,999	52 (10%)
$90,000 or above	49 (10%)
Disability	
Yes	47 (9%)
No	426 (85%)

[12] Not all respondents answered each question; hence why some percentages do not sum up to 100%.

Technology Ownership and Usage

Most respondents had access to a smartphone, internet, WiFi, and a data plan to use mental health apps. **Figure 5** shows a summary of respondents' smartphone use and internet access. Respondents used a smartphone (89%), a desktop or laptop computer (93%), a tablet (28%), and a mobile/cell phone but not a smartphone (6%). The majority of respondents (90%) used the internet either constantly or many times a day. Only 7% used the internet a few times a day. The majority of respondents had access to WiFi (90%) and most often accessed internet at home (92%).

Most (88%) had access to a mobile data plan. Of the respondents who had a mobile data plan, 32% were concerned about their mobile data plan when using their phone. Of the respondents who had a smartphone, 44% of respondents had concerns about having enough space to download apps.

Figure 5. Smartphone, WiFi, and Data Plan Access to Use Mental Health Apps

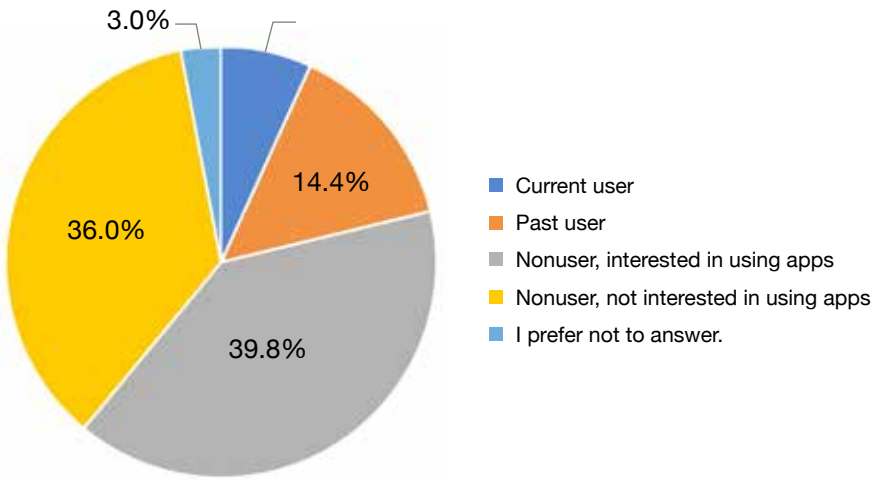
89% of respondents use a smartphone

90% of respondents have consistent access to WiFi

88% of respondents have access to a mobile data plan

Mental health app use, however, was not common. Figure 6 shows 76% of respondents had never used a mental health app. About half of these participants who never used a mental health app were interested in using one.

Figure 6. Smartphone, WiFi, and Data Plan Access to Use Mental Health Apps

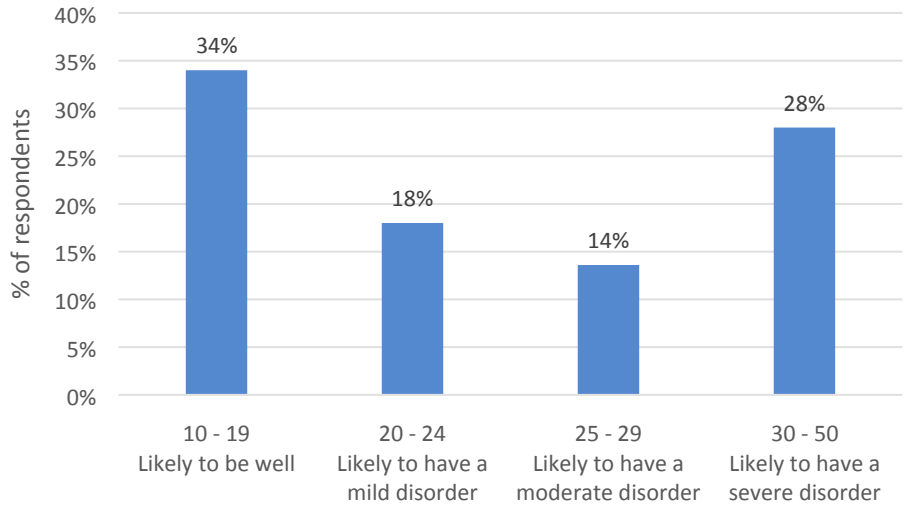


Current Wellness and Mental Health Needs

Stress, anxiety, and depression are common mental health concerns. Thirty-eight percent (38%) of respondents self-reported, using a single-item question, having experienced a mental illness. The most common mental health concerns were stress (44%), anxiety (41%) and depression (34%).

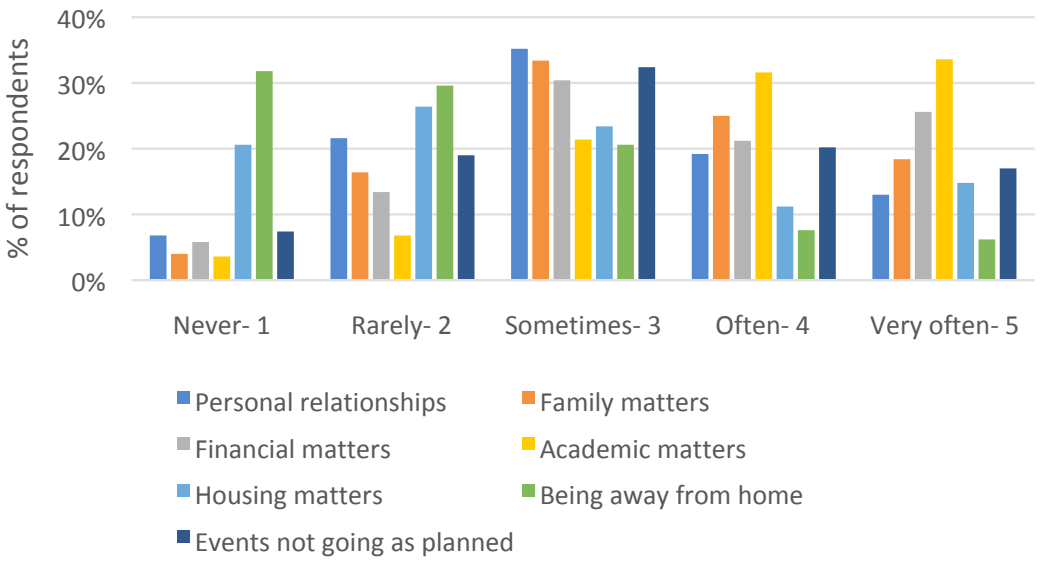
The majority of students experience some distress. Using the Kessler Psychological Distress Scale (Kessler et al., 2002), respondents were asked to rate ten statements related to how they have been feeling during the past 30 days (i.e., "During the past 30 days, how often did you feel tired out for no good reason?"). The statements were rated on a 5-point scale ranging from None of the time (1) to All of the time (5), with a total added score in the range of 10–50. A higher score indicates a higher level of psychological distress. **Figure 7** shows the distribution of scores. While these scores do not translate to clinical disorders, the scores can be used to estimate levels of distress, and can be interpreted as likelihood of having a mental disorder (psychological distress) as follows (Victorian Population Health Survey, 2001): 1) likely to be well (scores 10-19); 2) likely to have a mild disorder (scores 20-24); 3) likely to have a moderate disorder (scores 25-29); and 4) likely to have a severe disorder (scores 30-50). The mean score was 24.5 (SD = 10.0).

Figure 7. Distribution of Distress Scores among Respondents



Academics are a common source of stress. Using the 7-item version of the College Student Stress Scale (Feldt, 2008), respondents were asked to rate how often they were distressed or anxious in seven situations, on a scale from Never (1) to Very often (5). **Figure 8** shows that respondents were more often stressed on academic matters (yellow bar), and less often stressed about being away from home (green bar).

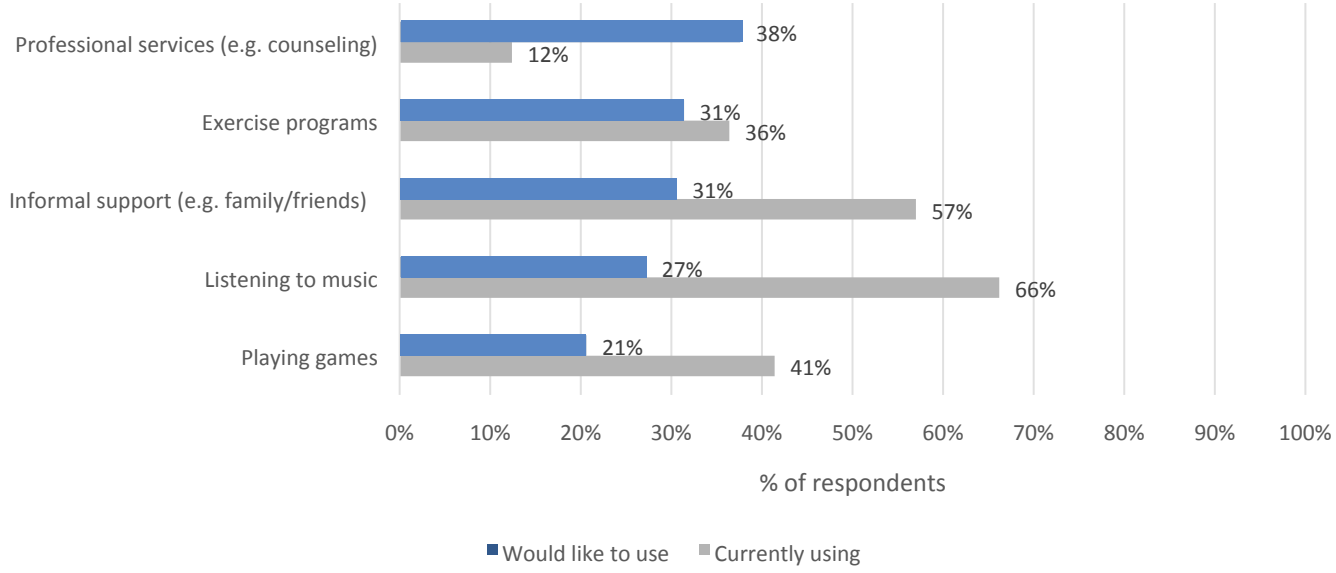
Figure 8. Sources of Distress among Respondents



Tools and Strategies to Manage Mental Health

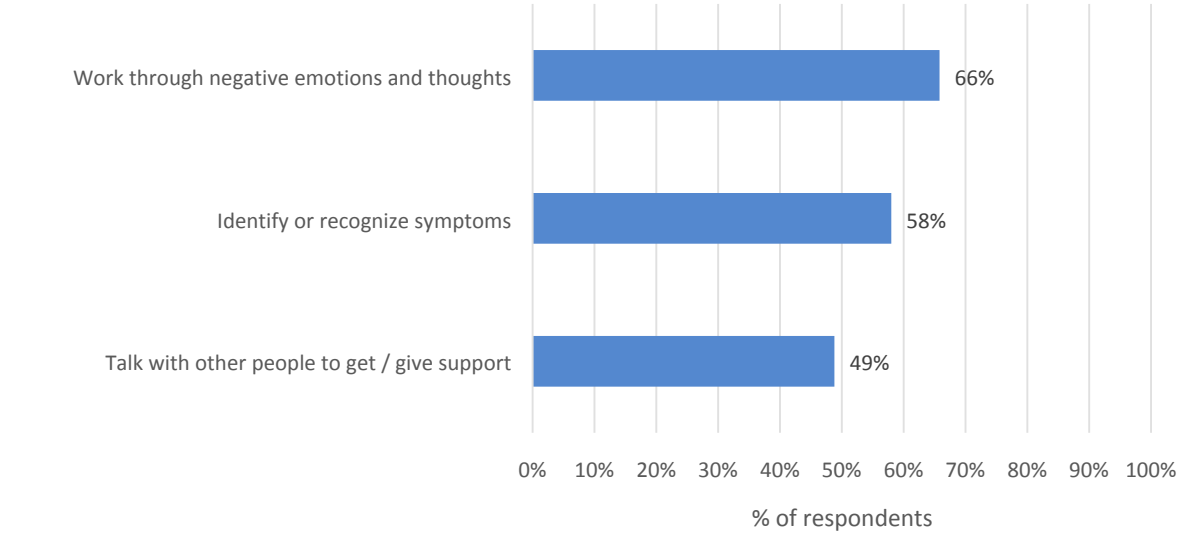
Informal strategies are commonly used, but professional services are wanted. Respondents were asked what strategies and resources they were currently using to manage their mental health, and what resources they would like to use. The most common strategies used to support mental health were informal, such as listening to music (66%), informal support such as talking to family/friends (57%), and playing games (41%). When asked what strategies and/or resources participants would like to use, the top three responses were professional services, such as counseling with a psychologist (38%), exercise programs (31%), and informal support (31%).

Figure 9. Strategies and Resources Currently Used and Would Like to Use



Resources to help manage negative emotions, identify symptoms, and talk with others are wanted. Respondents were asked what things they would like to be able to do, when thinking about using mental health resources. **Figure 9** shows that respondents would like to use mental health resources to work through negative emotions and thoughts (66%), identify and recognize symptoms (58%), and talk with other people to get/give support (49%).

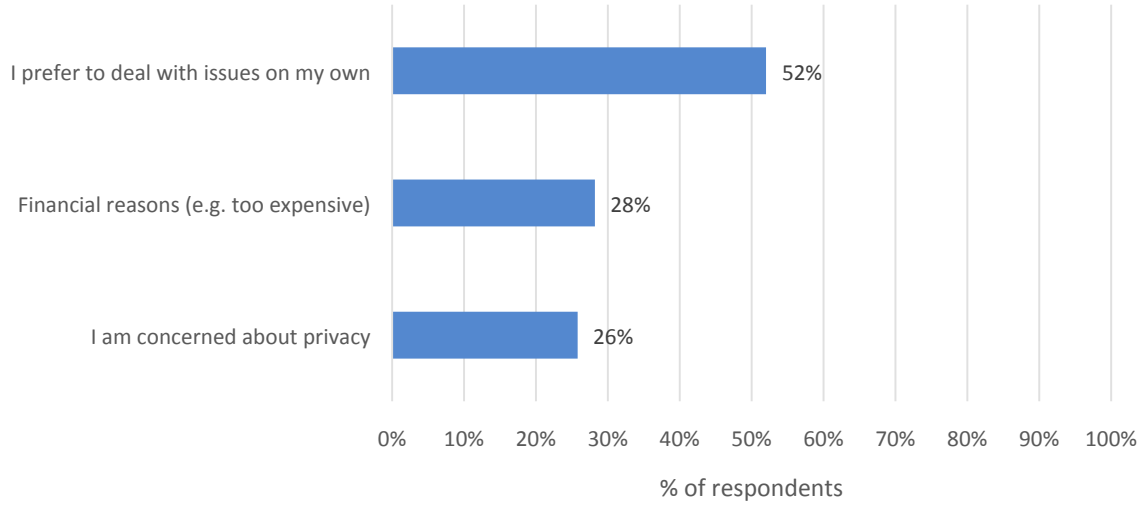
Figure 10. Needs Respondents Would Like Mental Health Resources to Address



Factors Affecting Engagement with Mental Health Apps and Other Resources

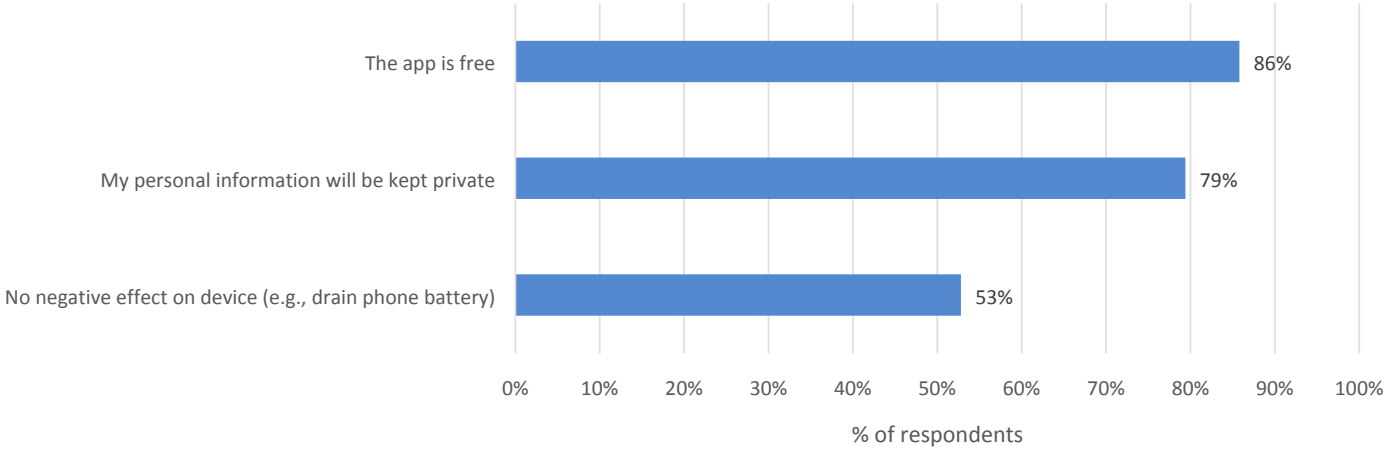
Generally, perceptions of mental health needs, privacy, and cost are barriers to resources. Respondents were asked what barriers they experienced in accessing mental health-related resources. **Figure 11** shows the most common barriers to access mental health-related resources were preferring to deal with issues on their own (52%), financial reasons (28%), and concerns about privacy (26%).

Figure 11. Common Barriers to Access Mental Health-Related Resources



Cost, privacy, and offline capabilities are specifically key for mental health apps. Respondents were also asked what considerations were important to them when using mental health apps. **Figure 12** shows the most important considerations about mental health apps were that the app was free (86%), personal information would be kept private (79%), and that the app had no negative effect on students' device, such as draining the battery (53%).

Figure 12. Important Considerations When Using Mental Health Apps



Preliminary Learnings from the College Student Survey

- Most students who participated in the survey have access to a smartphone, WiFi, and a data plan to use mental health apps. However, most had never used a mental health app before and only half of those students were interested in using one.

- The Help@Hand Collaborative should consider the following when selecting technologies to meet college student needs.

  - **Match demographics to technologies.** Spanish was a common primary language among respondents, and Mexican/Mexican-American/Chicano was the most commonly reported ethnicity. These demographics may influence engagement with Help@Hand apps, and it is important to consider what Help@Hand apps may match with the demographics of local communities.

  - **Match mental health concerns to technologies.** It is important to align the types of technologies and other resources used to support students with their mental health needs. Preliminary findings suggest stress, depression, and anxiety are the most prevalent mental health concerns. Though there are many different concerns and these results are preliminary, this could be a good starting point in thinking about types of Help@Hand apps to support such needs.

  - **Match requested strategies to technologies.** The most common strategies/resources used to manage health were informal, but respondents indicated they would like to use professional services. They would also like resources to help them to work through negative emotions and thoughts, identify and recognize symptoms, and talk with other people to get/give support. Although these results are preliminary, it may be useful to consider what Help@Hand apps may fulfill one or more of these requests.

  - **Address barriers to Help@Hand app use.** A common barrier to accessing mental health resources was financial reasons, and an important consideration for respondents when using mental health apps was that the app was free. In addition, another common barrier was a concern about privacy, and an important consideration about using mental health apps was that personal information would be kept private. Thus, it is important to address cost and privacy when considering Help@Hand apps. Further, many students reported that they prefer to deal with issues on their own. College students represent a unique target population, and it is important to think through specific preferences for accessing and integrating mental health support.

- Many students reported using informal strategies such as listening to music and playing games to manage their mental health. These could provide insight into potential areas to explore for outreach efforts and possibly even ways to integrate mental health into other spaces and conversations on campus. However, these findings are preliminary.

SPOTLIGHT: MARIN COUNTY

Innovative Approaches to Engage Stakeholders in the Time of COVID-19

Gathering feedback from stakeholders is a critical step in selecting an app to pilot, but reaching and engaging community members during COVID-19 has been difficult and required new innovations in outreach and engagement. Marin County has been at the forefront of developing and testing some of these new innovations.

Marin County identified two potential apps to pilot with isolated older adults. In order to make the final decision about which app to pilot, a critical next step was to gather feedback from potential older adult users before making a final decision. In March 2020, the impact of COVID-19 created a huge obstacle to obtaining this feedback. Part of this obstacle stemmed from the difficulty of reaching isolated older adults, many of whom were no longer receiving support through their regular in-person networks, and the challenge of soliciting feedback using technology platforms that require some level of digital familiarity to access. But Marin County did not allow this to deter their plans. **Marin County's Help@Hand Program Coordinator, Lorraine Wilson, MSW, successfully developed and implemented a remote structured user testing process to solicit stakeholder feedback**.

Marin County recognized that finding isolated older adults with enough technical skill to engage in remote user testing would be a challenge and they had to balance recruiting users who represented their target

population with obtaining feedback in this new and challenging time. Given that the apps were only available in English and Spanish, Marin County also needed to recruit Spanish speakers to test the Spanish version of the apps. **Lorraine tapped into her network, and with the support of Marin County's Advisory Committee, was able to find a group of individuals who were familiar with Zoom and were excited to engage with the Help@Hand project**. Users were enthusiastic about the opportunity to learn more about digital mental health and the potential to help others. Marin County also offered users incentives for their participation. Twelve individuals agreed to participate and formed two separate user testing cohorts; one included five older adults, and the other included a mix of Spanish speakers, peers, and older adults.

These individuals were asked to attend an introductory session on Zoom, a video conferencing platform, to learn more about their potential role participating in the structured user testing process. People who agreed then completed a Participation Agreement and demographic survey. Lorraine provided remote technical assistance to help anyone who needed assistance to install the apps on their personal devices and made herself available for questions during the seven days that users interacted with each app. The Help@Hand evaluation team created data collection instruments to gather feedback. **After seven days of using each app, participants completed an electronic survey and participated in a Zoom focus group**.

CalMHSA worked with Vendors to obtain test accounts and Lorraine held one-on-one sessions with each user to install the app. This proved to be a time-consuming process, particularly because devices and digital literacy varied across users. Some users had limited knowledge of technical language (i.e., scroll down, move the cursor) and lack of familiarity with their own devices. **Maintaining open and constant communication and practicing patience and flexibility created an environment where users felt comfortable seeking help and remained committed to the process**.

Counties/Cities that are interested in engaging stakeholders in the time of COVID-19 can learn from Marin County's process. A hired peer would have provided a different and important perspective on the process and could have assisted with outreach and recruitment. Lorraine also cautions against underestimating the amount of time that some tasks may take, such as: preparing for meetings, distributing incentives, and data collection. A great amount of time was dedicated to communicating with users and Vendors, and accommodating Vendors' schedule changes as they, too, experienced the impact of COVID-19. Lorraine reflected on her experience, "I am learning a lot and the support [CalMHSA and the Help@Hand evaluation team] provide is invaluable to me. It was one of the things that drew me to the project, and I am thankful that I have access to [CalMHSA and the Help@Hand evaluation team's] expertise."

As the effort expands, Marin plans to continually engage diverse groups of users to provide valuable feedback, and Lorraine has started brainstorming strategies with Marin County's Advisory Committee to include Spanish speakers and isolated older adults in Marin County's pilot, "My hope is that we can leverage relationships that already exist through service providers that have contact [with isolated older adults]," such as meals on wheels and In-Home Supportive Services.

This systematic approach allowed Marin County to obtain feedback from stakeholders that will help define Marin County's pilot plans and goals. As Lorraine stated, "We don't know what's better for people without hearing from them."

Lorraine Wilson, MSW, Marin County's Help@Hand Program Coordinator, successfully engaged stakeholders in remote user testing

"We don't know what's better for people without hearing from them."
– Lorraine Wilson

4 OUTCOMES EVALUATION AND DATA DASHBOARD

Key Points

- This quarter the Help@Hand evaluation team launched a national survey to examine how different mental illness labels affect an individual's responses to questions about mental health stigma. Results indicate that mental illness labels do not have a meaningful impact an individual's mental health stigma.

- The national survey also found high levels of anxiety and depression among those surveyed in Help@Hand Counties/Cities, California, and the United States. In addition, those who used mental health technology found them helpful.

- The Help@Hand evaluation team worked with the Help@Hand Collaborative to collect data from a number of sources, including the California Health Interview Survey (CHIS), California Health and Human Services (CHHS), County/City systems, and Technology Vendors.

OVERVIEW

The outcomes evaluation examines Help@Hand's overall impact in the state of California. Along with measuring outcomes, the evaluation includes a data repository.[13] Additionally, Orange County is interested in serving as a pilot site for developing a decision support dashboard to help Counties/Cities with program planning activities and monitoring. This chapter presents evaluation activities and learnings as follows:

- **Outcomes Evaluation**
  - o Measuring Mental Health Stigma
    - **Identifying Appropriate Labels**
    - **Mental Health Symptoms**
    - **Mental Health Technology Use and Usefulness**
  - o Accessing and Collecting Data from Different Sources
    - **California Health Interview Survey (CHIS)**
    - **California Health and Human Services (CHHS)**
    - **Data from County/City Systems and Technology Vendors**
  - o Learnings from the Outcome Evaluation
- **Data Repository and Data Dashboards**

OUTCOMES EVALUATION

The outcomes evaluation assessed Help@Hand's statewide effect on achieving its five shared learning objectives:

1. **Detect and acknowledge mental health symptoms sooner;**
2. **Reduce stigma associated with mental illness by promoting mental wellness;**
3. **Increase access to the appropriate level of support and care;**
4. **Increase purpose, belonging, and social connectedness of individuals served;**
5. **Analyze and collect data to improve mental health needs and service delivery.**

[13] A data repository refers to a large database infrastructure that allows for the collection, storage and management of datasets for data analysis, sharing and reporting.

Measuring Mental Health Stigma

A concern was raised at the "Conceptualizing and Measuring Mental Illness Stigma for Evaluation" workshop on how different individuals refer to mental health disorders differently, and that the language that we will be using in the stigma survey might influence the responses. As a result, it was agreed that it would be important to understand the implications of using different labels and the possible bias each might have. To address this issue, we fielded a survey in which we include all these terms. Each survey respondent received a single, randomly assigned term. The respondent was asked to complete the survey questions about mental health stigma using the randomly assigned label. The terms included the following: mental illness, mental health problem, psychological disorder, and emotional distress. A subset of individuals were able to use a term of their own choosing.

The information obtained from this survey will inform the stigma measurement by quantifying any bias that might exist when individuals respond to the stigma questions when any of these terms is used. Our hope is that the use of any of the terms does not introduce a bias, but if it does, we will be in a position to account for that influence.

This quarter the Help@Hand evaluation team launched the survey on Amazon Mechanical Turk (MTurk), a crowdsourcing platform, to explore how different mental illness labels affect an individual's responses to questions about mental health stigma. The survey also included questions on mental health symptoms as well as mental health technology use and usefulness.

Data collection occurred across all 50 states for one week in April, May, and June starting on approximately the 6th of each month. We plan to continue data collection for a total of four months. Each time the survey is posted, approximately 1,750 people can participate. Individuals were compensated $6 for the completion of the survey. A total of 4,344 surveys were completed in the quarter. A total of 4,344 surveys were completed in the quarter. **Table 9** displays general demographics of the respondents.

Table 9. Demographics of MTurk Survey Respondents (N = 4,344)

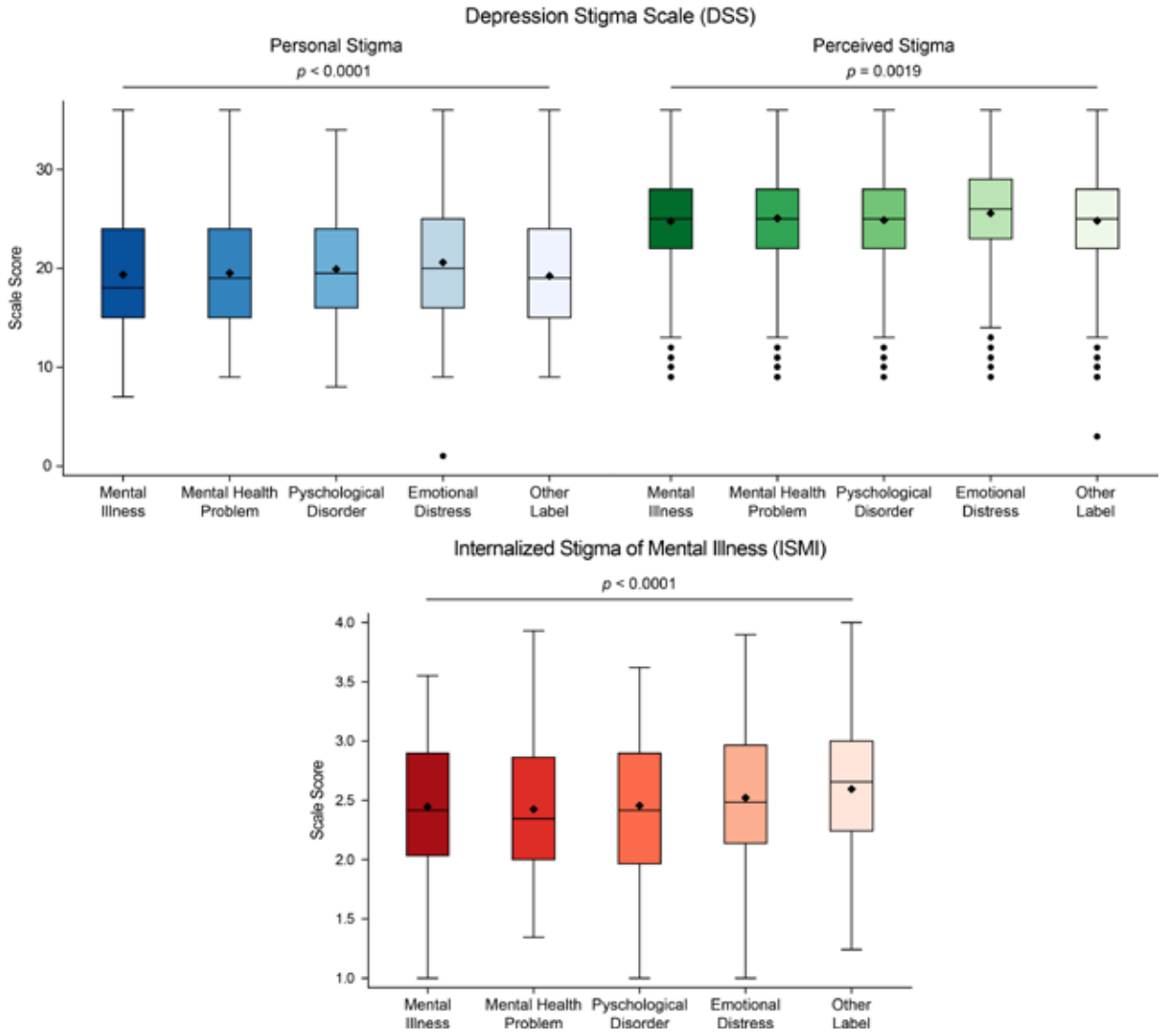
Demographics	Mean (SD)
Age	36.6 (11.7)
	n (%)
Gender	
Male	2,488 (57.8)
Female	1,820 (42.3)
Race/Ethnicity	
White	2,509 (58.0)
Latino or Hispanic	914 (21.1)
Asian	401 (9.3)
Black or African American	322 (7.4)
American Indian or Alaska Native	26 (0.6)
Other	22 (0.5)
More than one race	133 (3.1)
Education	
Less than High School	20 (0.5)
High School or Equivalent	864 (19.9)
4-year College or University	2,278 (52.5)
Graduate or Professional School	726 (16.7)
2-year Junior or Community College	339 (7.8)
Vocational, Business, or Trade School	109 (2.5)

Identifying Appropriate Labels

To evaluate a label's impact on mental health stigma, participants were randomly assigned to one of the following terms: mental illness, mental health problem, psychological disorder, emotional distress, and one allowed them to use a term of their own choosing. These terms were placed into well-established, evidence-based scales (a series of questions that ask about the same attitude, feeling, or idea).[14]

Figure 13 shows the results from the comparison of the mental illness labels. The use of the labels of mental illness, mental health problem, and psychological disorder did not result in any significant differences in how individuals responded to questions on mental health stigma. However, when the label emotional distress was used, or the individual was able to fill in a label, the resulting stigma measure were significantly different from the other terms. Although the results reveal that the label used in the mental health stigma scale does have a statically significant effect on the measure of stigma, the small magnitude of the difference suggests that the labels may not produce clinically meaningful differences. These findings when taken together suggest that in practice, the use of any one of these labels would be acceptable in a mental health stigma scale.

Figure 13. Differences in Mental Health Stigma Based on Labels[15]



[14] The scales used were the Depression Stigma Scale (DSS) and its corresponding sub-scales of Perceived Stigma and Personal Stigma, as well as in the Internalized Stigma of Mental Illness scale (ISMI). The survey prompted all participants to complete the DSS, but only those who identified as having the mental illness term responded to the ISMI.

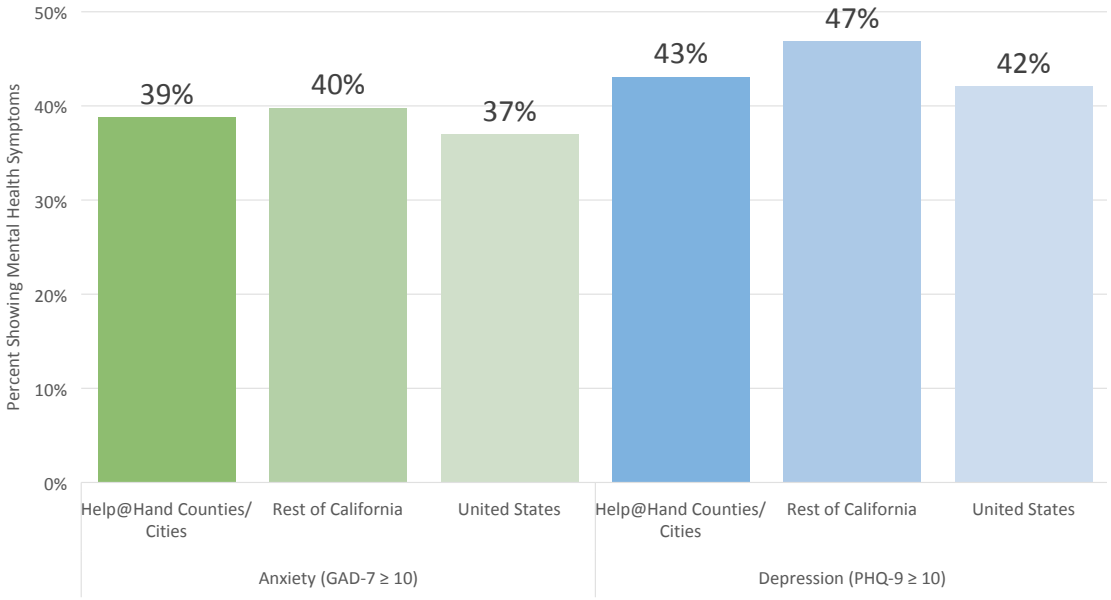
[15] Means were calculated for those who responded to all items of the scale/subscale. An analysis of variance (ANOVA) was used to test if there was a difference in mental health stigma based on the label used in the stigma measure. A p-value of less than 0.5 denotes a statistically significant.

Mental Health Symptoms

In addition to examining different metal illness labels and their effect on mental health stigma, the Help@Hand evaluation team collected data on participant's mental health symptoms. The survey included the Patient Health Questionnaire (PHQ-9) and the General Anxiety Disorder scale (GAD-7), which respectively measure depression and anxiety severity. A score greater than or equal to 10 on the PHQ-9 and GAD-7 indicates clinical symptoms.

Figure 14 shows the percent of survey respondents who are depressed and anxious in Help@Hand Counties/Cities, the rest of California, and in the entire United States. The results of depression and anxiety are much higher than the average for the United States, with 8.1% identifying as depressed in the past two weeks by the Centers for Disease Control (CDC) (Brody, 2018) and 19.1% identify as having anxiety in the past year by the NIH (National Institute of Mental Health, 2017). However, these rates of depression and anxiety reported by the CDC and National Institute of Health (NIH) were prior to the COVID-19 pandemic.

Figure 14. Prevalence of Depression and Anxiety



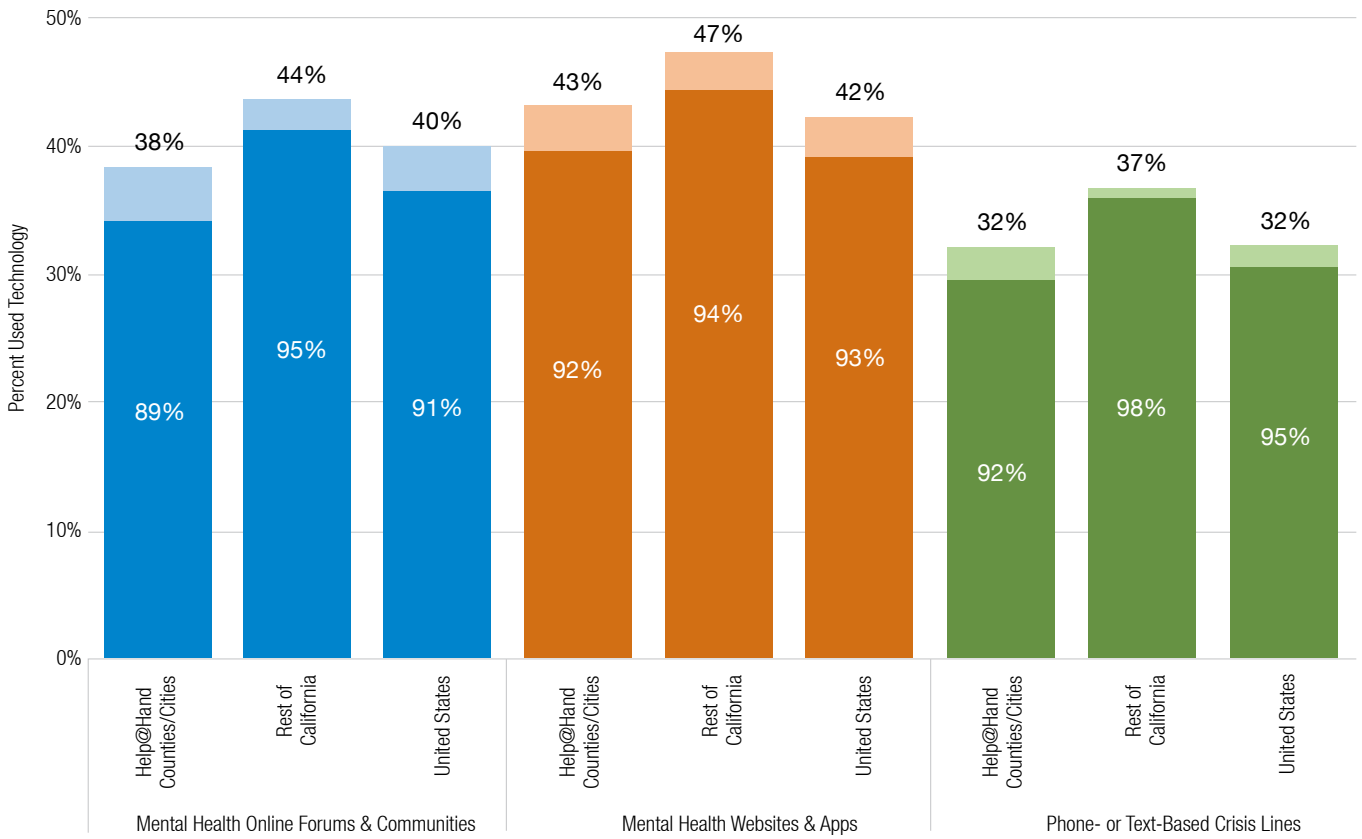
Mental Health Technology Use and Usefulness

Survey respondents also were asked if they used any type of mental health technology (i.e., mental health online forums or communities; mental health websites and apps; phone-based or text-based crisis lines). Respondents who used a mental health technology were also asked if they found the technology useful.

Figure 15 depicts the percent that used each mental health technology. Mental health websites and apps were the most commonly used technology, with 43% in Help@Hand Counties/Cities, 47% in the rest of California, and 42% in the United States survey sample.

Of those who used the technology, the percent of those who found it useful is also shown in **Figure 15** (the darker shade of each bar). Rates of mental health technology use varied across the Help@Hand Counties, the rest of California, and the entire United States survey sample. However, those who used a mental health online forums or communities, mental health websites and apps, or phone-based or text-based crisis lines, found it useful 89-98% of the time.

Figure 15. Mental Health Technology Use and Usefulness



Accessing and Collecting Data from Different Sources

The Help@Hand evaluation team continued to work on developing infrastructure and processes for outcomes data collection.

California Health Interview Survey (CHIS)

CHIS (the largest state health survey in the nation asks questions on a wide range of health topics to a random sample of teens and adults throughout the state of California. In addition to collecting data from CHIS' routinely asked survey[16], the Help@Hand evaluation team and CalMHSA worked with CHIS to include additional questions related to Help@Hand. CHIS was contracted to field their survey with the additional questions between 2019-2020. This quarter the Help@Hand Leadership approved extending the survey collection to 2021-2022.

California Health and Human Services (CHHS)

Last quarter CHHS and its Institutional Review Board (IRB) approved the Help@Hand evaluation team request for data: 1) Office of Statewide Health Planning and Development (OSHPD) inpatient and emergency department data and 2) vital statistics data. Although OSHPD data has not been received to date, vital statistics data was received from the California Department of Public Health (CDPH) this quarter.

Analysis of inpatient, and emergency department, and vital statistics will allow us to compare access to care, access to appropriate levels of care, and outcomes across Help@Hand Counties/Cities, as well as similar Counties/Cities not participating in Help@Hand, which will serve as controls.

Data from County/City Systems and Technology Vendors

County/City and Technology Vendor systems (i.e., apps) provide important data needed to understand the full impact of Help@Hand in communities and in the state. As mentioned earlier in the report, the Help@Hand evaluation team worked closely with CalMHSA, Counties/Cities, Technology Vendors, and other stakeholders to plan how to access data from the technologies, County/City systems, and other sources.

[16] The survey can be found at: https://healthpolicy.ucla.edu/chis/design/Pages/questionnairesEnglish.aspx

Learnings from the Outcomes Evaluation

- Although Amazon Mechanical Turk allowed for a large amount of data to be collected on a national sample, it may not be a representative sample. Results from the survey examining how different mental illness labels affect an individual's responses to questions about mental health stigma indicate:
  - Mental illness terminology (i.e. mental illness, mental health problem, psychological disorder, emotional distress, or other labels) does not have a meaningful impact on an individual's mental health stigma.
  - There are high levels of anxiety and depression in the survey sample across the Help@Hand Counties/Cities, California, and the United States.
  - A high percentage of those who use mental health technologies find them useful.
- Accessing CHHS data is time consuming and requires substantial efforts. As a result, those requesting such data should constantly assess the benefit and necessity of collecting this data.
- Collaboratively working with multiple stakeholders provides an opportunity to effectively access data from Counties/Cities and Technology Vendors. It also allows for the collection of data that may answer questions posed by the different stakeholder perspectives. (i.e., Technology Vendors may request data to understand how to enhance their products, whereas County/City staff may request data to improve their programs.)

DATA REPOSITORY AND DATA DASHBOARDS

The Help@Hand evaluation team in partnership with Orange County had planned to pilot decision support dashboards before dissemination this work to other Counties/Cities. This work is paused in order to allow Orange County to focus on other project priorities and activities.

RECOMMENDATIONS

Based on evaluation activities and learnings presented in this report, the Help@Hand evaluation team recommends the following for the overall Help@Hand Collaborative and the individual Help@Hand Counties/Cities.

RECOMMENDATIONS TO THE HELP@HAND COLLABORATIVE

- COVID-19 created many challenges that needed to be overcome throughout the Help@Hand program. However, Covid also created opportunities – in particular an urgency that compelled processes to streamline and quickly problem-solve barriers. Identifying and leveraging these streamlined processes will be important for future implementations.
- Continue to develop processes and tools for regular and integrated communication between Counties/Cities, CalMHSA, Help@Hand evaluation, and other stakeholders for updates and collaborative planning.
- Continue to encourage Counties/Cities to share their implementation experiences and lessons learned during Collaborative forums, such as the Tech Lead calls. Counties/Cities commented that "lessons learned" are being captured in different ways. They recommend developing a streamlined process to capture, synthesize, and disseminate lessons learned.
- Counties/Cities often are not aware of helpful materials available through the Sharepoint. Although CalMHSA has taken steps to address this, it continues to be an issue. Tools and communication messages should continue to be developed to address the issue.
- Efforts are currently underway to translate materials for dissemination to key target audiences. As recommended as part of best practices, consider including stakeholders to ensure appropriate cultural tailoring of translated documents.
- Furthermore, consider the materials to be selected for translation and dissemination. There are a number of strategies for success, including selecting a medium for dissemination that suits the message (e.g. consider use of video or infographic. Identify the audience and tailor the message – it is important not to overlook the intended audience and consider specifically tailoring each message to that audience.
- Negotiate contracts on behalf of Counties/Cities that ensure peer chat and/or other apps address limited assistive technologies, limited language availability, and/or limited tailored content that would meet the need of certain target populations.
- Given that several Help@Hand Counties/Cities are interested in peer chat apps, conduct a cross-collaborative learning session to understand the current peer chat marketplace, discuss target population needs related to peer chat apps, and share relevant experiences.
- Continue to create and provide much needed digital mental health literacy training to target populations.
- Continue to share best practices and lessons learned related to addressing internet/data access issues, development of safety protocols and crisis resources. Update existing protocols and resources as needed.
- There are app technologies that have been made available on a limited basis for free to the public during Covid. Consideration of these products may or may not be useful for County implementations.
- Review preliminary findings from the Los Angeles County/El Camino College Survey presented in this report to support those Counties/Cities planning to support community college students and/or transitional aged youth (TAY). Although findings are preliminary, they can provide an initial understanding of the population needs, as well as identify apps and cross-collaborative efforts to meet these needs.

- These findings also shed light on the importance of understanding the unique experiences of people who represent key target audiences for selecting products that might have the greatest success in a specific group of people.
- Counties/Cities have indicated that being part of this Collaborative has been extremely helpful for them getting feedback and working through issues that arise. There may be other ways for them to benefit from being part of the Collaborative, like helping each other with app testing and joining other Counties/Cities' meetings (as suggested by Santa Barbara County).
- Data is the new oil of the 21st century. Understanding what data Counties/Cities will have access to and what data needs to be collected, both as part of Vendor agreements and by other key stakeholders (i.e., Help@Hand evaluation, local evaluation) continues to be a critical discussion point. Conversation around minimum data collection is important and complex. Some Counties/Cities are comfortable working with only available Vendor provided data, whereas others are open to disqualifying a Vendor if unable to provide this data. CalMHSA and the Help@Hand evaluation can continue to work with Counties/Cities to determine if there is a defined set of data Counties/Cities expect from Vendors. This information will be important for guiding Vendor negotiations.

RECOMMENDATIONS TO HELP@HAND COUNTIES/CITIES

- Counties/Cities are finding ways to support the community's mental health needs during COVID-19. This process has required some to launch products sooner than they anticipated and others to launch during these unique times. Counties/Cities understand that there are additional hurdles to be overcome and welcome feedback from the Collaborative to identify these potential hurdles either before or during their launch.
- Counties/Cities should engage CalMHSA, the Help@Hand evaluation team, and other experts early in the technology exploration and selection phase as well as the pilot process to allow adequate planning for efficient and effective processes and evaluations that align with learning goals.
- Launch strategies, such as engaging agency leadership, early and continuously monitor the strategies in order to facilitate early program success and eventual sustainability.
- Counties are searching for ways to engage their stakeholders especially amidst the COVID-19 situation. Connecting to target audience members (i.e., through marketing efforts) has been challenging. Develop partnerships with local agencies and resources (i.e., NAMI, religious institutions, peer networks) early in the process to facilitate reaching target audience members.
- Identifying and tracking the various stages of technology implementation enables Counties/Cities to understand how users will use a specific technology and what facilitators or barriers might contribute to sustaining the technology.
- Counties/Cities should identify and design opportunities to streamline user consent and referral processes to promote greater likelihood of adoption and client engagement.
- Counties/Cities should periodically reflect on their program experience, achievements, and lessons learned to celebrate progress and identify opportunities to improve programs as well as technology implementation. Reflection may include, but is not limited to, completing lessons learned documents or participating in evaluation interviews.
- Staffing is key on the project. It is important to have a diverse workforce that can meet the demands of various communities. Consider opportunities, perhaps created by COVID-19, that allows for increased employment and/or shifted work roles (i.e., see Riverside's Spotlight for examples).
- Publicly available peer chat apps have limited assistive technologies. Consider focus groups with individuals who are blind or visually impaired, illiterate, or have a learning or cognitive disability to understand their needs, explore appropriateness of potential apps, and inform discussion on accessibility capabilities with selected Technology Vendors.

- Most peer chat app content is available only in English and not tailored for certain target populations. Pilot apps with target populations to gather feedback on their cultural appropriateness. Consider integrating these apps within broader culturally-relevant programs.
- Given that peer chat functions are not available offline, Counties/Cities should consider the impact on use among target populations. Provide digital mental health literacy training to ensure potential users understand connectivity to WiFi and internet data to avoid unexpected charges.
- Peer chat apps should not be used in isolation since it is not clear to what extent peer interactions are moderated or by whom. Instead, peer chat apps should be part of a broader treatment plan, where users can receive support when needed.
- Counties/Cities should work with clients to develop safety protocols and ensure resources are available in crisis.
- Peer chat app become more useful as they are adopted by more users, but may not be adopted until they are useful (i.e., chats are responded to in a timely fashion). Using a trained peer workforce may be helpful to ensure usefulness until a critical mass of organic users is reached.
- Counties/Cities should consider active approaches to enhance uptake and engagement with these apps given that uptake and sustained use of peer chat apps was low (as shown by retention data) and that an engaged community is essential to meaningful use.
- Consider apps that allow students to talk with other people to get and give support (including professional services). Apps that work through negative emotions and thoughts, and/or identify and recognize symptoms may be useful too.
- Counties/Cities must maintain students' privacy and consider cost to students (selecting free apps when possible).
- As raised during a Tech Lead call, there is no FDA approval for mental health apps at the moment, but some Vendors have a process for seeking this approval once it becomes available. Counties/Cities who are interested in having an FDA-approved app should confirm whether vendors have a process for securing this approval. For example, Los Angeles introduced the idea of digital health formularies as an alternative in response to FDA certification.

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APPENDIX A: COUNTY/CITY SPECIFICS

Each Help@Hand County/City completed the following tables that describe their program information, accomplishments, lessons learned, and recommendations.

City of Berkeley	Quarter 1 (Jan–Mar 2020)	Quarter 2 (Apr – Jun 2020)
Tech Lead	• None	• Kirsten White • Karen Klatt
Implementation Site	• TBD	
Team Composition	• Tech Lead, Behavioral Health Director, MHSA Coordinator, Peer, Project Coordinator	• Steven, BH Director • Karen, MHSA Coordinator • Jaime, Peer Lead • Kirsten, RDA Consultant • Nicole, RDA Consultant
Target Audience	• TBD	• TAY; isolated seniors; communities of color, including African Americans, Latina, etc.; general population of Berkeley
Products In Use/ Planned	• TBD	• Under review
Implementation Approach	• TBD	
Other Unique Qualities (of target audience, implementation, or other program aspect)	• TBD	• Prefer to engage minority-owned vendors
Milestone	• Not applicable	• Peer Lead allocated to project • Local consultants contracted and onboarded to support app selection and developed plans for implementation
Lessons Learned	• Not applicable	• Time required for processes and approvals • Project required dedicated resources • Organizational change management is as important as the technology
Recommendations	• Not applicable	

Kern County	Quarter 1 (Jan–Mar 2020)	Quarter 2 (Apr – Jun 2020)
Tech Lead	• Lamar K. Brandysky, LMFT	• Lamar K. Brandysky, LMFT
Implementation Site	• Self-Empowerment Team	• Self-Empowerment Team
Team Composition	• Project Lead, Peer Lead, 2 Peers, PIO, Marketing Associate	• Project Lead, Peer Lead, 1 Peer, PIO, Marketing Associate
Target Audience	• Clients with serious mental illness • Kern County Residents	• Clients with serious mental illness • Kern County Residents
Products In Use/ Planned	• App Brochure, 2nd Edition – English and Spanish versions • App Brochure, 3rd Edition (planned)	• App Brochure, 2nd Edition – English and Spanish versions • App Brochure, 3rd Edition (planned)
Implementation Approach	• Wide distribution of the App Brochure	• Wide distribution of the App Brochure
Other Unique Qualities (of target audience, implementation, or other program aspect)	• Offer clinician education on App Guide (planned) • Support other Help@Hand Counties/Cities (Mono, Modoc, and Santa Barbara) develop their own tailored App Guide • Adapt App Brochure for Nevada, Fresno, San Bernardino, and Inyo Counties to publish their own App Guide	• Offered clinician education on App Guide (planned) • Supported other Help@Hand Counties/Cities (Mono, Modoc, and Santa Barbara) develop their own tailored App Guide • Adapted App Brochure for Nevada, Fresno, San Bernardino, and Inyo Counties to publish their own App Guide

Continued on next page

Kern County	Quarter 1 (Jan–Mar 2020)	Quarter 2 (Apr – Jun 2020)
Milestone	• Published the 2nd Edition of "The Peers' Guide to Behavioral Health Apps" App Guide in English and Spanish • Created a version of the app guide for Modoc, Mono, and Santa Barbara Counties that included content modifications and printing set-up • Prepared and Implemented a four-hour Peer Workshop on empowerment training for Kern BHRS and contracted Peers • Empowered Peers though the app guide development and dissemination • Prepared and hosted two-day Digital mental health literacy training for Help@Hand Peers • Presented App Brochure to County Board of Supervisors in January • Presented to the Kern BHRS Management and to the Kern BHRS contract CEOs • Started systemic distribution to other Kern County agencies	• The state-wide medical emergency declared by the governor has resulted in a pause on all Help@Hand activities.
Lessons Learned	• The proposed apps need to be thoroughly vetted prior to piloting with clients. A prime role of County mental health is to assure the provision of safe products to their vulnerable population. • Digital literacy takes one-on-one coaching which is time consuming and labor intensive. • Consumers benefit from basic digital literacy training. • Collaborating with fellow counties is fruitful and productive. • Working with County agencies requires an abundance of patience and perseverance. • It is vital that the peer employees not only have lived experience, but that they will have progressed sufficiently in their recovery that they feel free to share details of their journey. This sharing of surviving and thriving in their recovery is a prime issue to benefit our consumers and members.	• Same as Q1
Recommendations	• Focused on producing a product. Time and energy can be spent on process and procedures with no resulting product	• Same as Q1

Los Angeles County	Quarter 1 (Jan–Mar 2020)	Quarter 2 (Apr – Jun 2020)
Tech Lead	• Katherine Steinberg, MPP, MBA • Alex Elliott, MSW • Ivy Levin, LCSW	• Katherine Steinberg, MPP, MBA – Reassigned mid May 2020 • Alex Elliott, MSW – Served as a liaison for Painted Brain/ Peer contributions
Implementation Site	• Harbor UCLA DBT program • Peer Resource Center (planned) • Geriatric Evaluation Networks Encompassing Services Intervention Services (GENESIS) outpatient program for older adults (projected for pilot) • Telecare Los Angeles Older Adults (LAOA) Full Service Partnership (FSP) program (projected for pilot)	• Harbor UCLA DBT program • Peer Resource Center (planned) All pilots were placed on hold due to COVID
Team Composition	• Program Lead/Project Manager, Chief Medical Officer (Executive Sponsor), Behavioral Health Director, 2 Tech Leads, Chief Information Officer, IT Project POC, Chief of Peer Services, Evaluation Lead, Privacy SME, IT Security SME, Harbor UCLA Clinical Champion, Public Information Officer	• Program Lead/Project Manager, Chief Medical Officer (Executive Sponsor), Behavioral Health Director, 2 Tech Leads, Chief Information Officer, IT Project POC, Chief of Peer Services, Evaluation Lead, Privacy SME, IT Security SME, Harbor UCLA Clinical Champion, Public Information Officer
Target Audience	• Transitional age youth and college students • County employees • Complex needs individuals (i.e., those with multiple and repeated hospitalizations) • Individuals and family members uncomfortable accessing community mental health services seeking de-stigmatized care and supports for well-being • Existing mental health clients seeking additional support or seeking care/support in a non-traditional mental health setting	• All Los Angeles County residents in need of support due to COVID. • County employees • Existing mental health clients seeking additional support or seeking care/support in a non-traditional mental health setting.
Products in Use/Planned	• Headspace (planned) • Modified Mindstrong Health App • CredibleMind (projected for pilot) • Uniper (projected for pilot) • MindLAMP (projected for pilot)	• Headspace for COVID-19 response made available • Modified Mindstrong Health App

Los Angeles County	Quarter 1 (Jan–Mar 2020)	Quarter 2 (Apr – Jun 2020)
Implementation Approach	• Headspace for current DBT clients (possible COVID-19 response) • Headspace for individuals visiting the DMH Peer Resource Center • CredibleMind for isolated populations at higher risk for more serious complications from COVID-19 • Uniper for current DMH clients in the GENESIS outpatient program for older adults • Uniper for current older adult clients with internet access enrolled in the Telecare Los Angeles Older Adults (LAOA) Full Service Partnership (FSP) program • MindLAMP for clients in Harbor UCLA DBT program	• Headspace for COVID-19 response made available to all county residents • MindLAMP for clients in Harbor UCLA DBT program • Headspace for individuals visiting the DMH Peer Resource Center
Other Unique Qualities (of target audience, implementation, or other program aspect)	• LAC DMH is exploring how to use apps and platforms that have already gone through internal review to meet the increased needs of those impacted by COVID-19 (COVID-19 response)	• Rapid deployment, without pilot process, of Headspace to meet the increased needs of the community due to COVID-19 • Streamlined all DMH communications to ensure community is aware of resources available
Milestones	• Continued development and refinement of pilot proposal documents • Coordinated calls between vendors, LAC IT security, LAC program leads, and CalMHSA to get questions answered • Began evaluation planning and proposal refinement with UCI and CalMHSA • Learning collaborative at PRC: Discussion for the Development of a Guide to Wellbeing Apps Brochure • Development of Painted Brain App Evaluation Matrix • Finalized Guide to Wellbeing Apps Brochure and shared with the Help@Hand Collaborative • Gathered free resources offered in response to COVID-19 and shared with the Help@Hand Collaborative • Created a dynamic QR code for App Brochure • Presented pilot plans to Help@Hand leadership group (all pilots approved by Collaborative) • Development of Digital Health Literacy Modules by Painted Brain and associated DMH review • Headspace presentation at Countywide Supervisors Forum • Headspace on-site meeting: Getting started with Headspace with Tom Freeman, Engagement Manager • Development of request for information (RFI) Screening Tool w/ Monterey County • Participated in Help@Hand Language/Monolingual Working Group • Clinical Peer Review Presentation for the Quality, Outcomes and Training Division: Resources to help Deaf, Hard of Hearing, Blind and Physically Disabled Populations access and use Assistive Technology • Updated Help@Hand LA Charter and committee structure • Collaborated with UCI to develop the Community College students digital mental health baseline needs assessment	• The Leadership Committee reviewed and approved three pilot proposals from LA County on April 9th, 2020. • Headspace Plus subscription made available to all Los Angeles County residents as part of COVID rapid response in early May • Updated Peer-developed Digital Mental Health Literacy Modules to adapt for virtual training sessions • Engaged in the development of specific modules of digital health literacy curriculum and training to include telehealth etiquette and use of selected DMH telehealth platform (Vsee) by Peers • Held Digital Mental Health Literacy virtual trainings for Service extenders, Community Health Workers, and Peers champion • Translated Guide to Wellbeing Apps Brochure to Spanish and disseminated to the Help@Hand Collaborative • Various outreach and communication efforts to increase awareness and engagement with Headspace and the Guide to Wellbeing Apps • LACDMH LE provider completed interview on Apps to Support Wellbeing at Compton Pride
Lessons Learned	• Establish a central point-person as the lead project manager and leadership representative to triage and delegate tasks to team members and govern implementation and contracting • Refocus technology selection from customization and development to employment of technologies currently in use in health and academic settings • Even more due diligence is required around product functionalities and offerings to confirm they meet county expectations and needs prior to contracting • Ensure digital health curriculum for clients is also given to providers in a condensed form • Local learning collaborative approach allows for regular feedback from key stakeholders and supports development of organizational culture of digital health readiness • Plan for significant training and monitoring for implementation sites to allow for greater iteration and engagement opportunities among staff • Continue to collect understanding of unmet needs for target audience to help inform technology selection, piloting, and scaling • Articulate success metrics and plan for collection ahead of pilot implementation (identify the quantitative and qualitative metrics to measure effectiveness with digital mental health and wellness applications)	• As the emotional impact of COVID-19 and the stay-at-home orders became increasingly evident, the County determined that all resources needed to be applied to reaching the community.

Los Angeles County	Quarter 1 (Jan–Mar 2020)	Quarter 2 (Apr – Jun 2020)
Lessons Learned (continued)	• Utilize hands-on demos, videos, and visualizations to engage stakeholders in learning about the features of Tech Suite technologies	
Recommendations	• Be flexible and adaptable to adjust pilots to evolving needs and priorities • Allow for differences in approach across Collaborative while sharing learnings and experiences broadly • Stakeholders are looking for SME to curate resources on their behalf to make selection of digital health resources easier • Work closely with internal DMH IT department starting early in process, particularly as it relates to privacy and security reviews • Create a process for internal SME reviews of technologies and approach to communicating updates across SMEs • Facilitate more open sharing, communication and learning across counties and among counties and vendors (include tech, evaluation, marketing vendors and CalMHSA) • Work closely across admin, program leads, vendors, and evaluators on the aligned pilot plans • Regular learning collaborative opportunities supports readiness for digital health implementations • Increased communication between counties and CalMHSA about process requirements is helpful • Utilize local marketing/design resources to develop tools and communication materials quickly and allow for easy iteration • Maintain realistic goals about timeframe for internal IT review of vendors under consideration and CalMHSA contracting timeline • Consider piloting technologies that require only minimal customization to the public mental health space, rather than product development. Wait on customization efforts until after initial usability is demonstrated • Plan early which success metrics will be met for advancing to spread of technology with the county • Consider the spread plan during pilot planning • Engage expertise in digital health piloting • Engage dual SME and certified Peers for digital health curriculum development • Consider a phased approach to roll-out, starting with only 1 or 2 counties per technology, with clear success metrics • Execute vendor contracts linked to clear milestones of project success • Iterate on project budget to ensure it reflects the vision for a suite (or menu) of technologies to increase access to mental health and wellbeing and ensure transparency to counties about budget and costs of deliverables requested • Stay up to date on the mobile digital health technologies and allow for new technologies to be a part of the selection on on-going basis • Bring lessons learned from other organizations that have created tech suites back to this Collaborative • Compare products on the Tech Suite bench to what is available in the digital mental health and wellness market • Despite pressure around reversion, ensure appropriate due diligence and clarity around the process and timeline before pushing timelines forward • Facilitate meaningful collaboration and sharing among counties (facilitate a shared understanding of what collaboration means to the Collaborative) • Ensure all information is provided to the counties in a timely manner so that counties can drive decision making and apply learnings in an expedited manner • Ensure there is clarity with budgeting on what dollars are available from funding for local operationalization so counties can plan and execute on plans efficiently • Stay up to date on the free mobile digital health technologies that are available such as apps available through county libraries and the Statewide Peer Run Warm Line • Monitor Tech Suite technologies analytics dashboards to inform quality improvement, outreach and engagement strategies • Eliminate barriers to individuals' participation in the Tech Suite by spending time understanding what those potential barriers might be (i.e., increase the number of USB ports in clinics and drop-in centers to support charging devices, assist clients with accessing phones through the California Lifeline Program)	• Be flexible and adaptable to changing needs. • Collaborate effectively to respond to the rapidly changing environment in the community.

Marin County	Quarter 1 (Jan–Mar 2020)	Quarter 2 (Apr – Jun 2020)
Tech Lead	• Chandrika Zager • Lorraine Wilson, MSW	• Chandrika Zager • Lorraine Wilson, MSW
Implementation Site	• Not applicable	• Not applicable
Team Composition	• Behavioral Health Director, Peer, MHSA Coordinator, Tech Lead	• Behavioral Health Director, Peer, MHSA Coordinator, Tech Lead
Target Audience	• Older Adults (particularly those who are isolated)	• Older Adults (particularly those who are isolated)
Products In Use/ Planned	• Uniper (Testing) • myStrength (Testing) • Happify (Testing) • Wysa (Testing)	• Uniper • myStrength
Implementation Approach	• TBD	• TBD
Other Unique Qualities (of target audience, implementation, or other program aspect)	• Builds an intergenerational component (planned) • Obtain stakeholder feedback through online venues (COVID-19 response); will require both group and individual coaching and a much more drawn out process	• Virtual Focus Groups (200 hours, 12 participants) • All data gathered remotely – Zoom, Doodle, Online Surveys, DocuSign
Milestone	• Business Advisory Committee established and will hold first meeting 4/16 • Identified two groups of stakeholder testers (congregation of older adults and peers) • Request for proposal issued to identify a trainer experienced with older adults to assist with digital literacy training • Recruitment is underway to hire a Peer for the project	• Advisory Committee met 4 times and helped recruit focus group members, outline outreach plan, and shared additional considerations for local evaluation • Tech4Life hired – contractor experienced in remote coaching in use of tech for older adults • Peer recruitment – Anticipated start mid-late August
Lessons Learned	• Selection of an app is a slow process and having a shared understanding of the limits of language capacity among the apps in the pilots needs to be communicated broadly • The redirect of the project to online stakeholder feedback sessions for older adults, who are not necessarily highly technologically literate, will require skill in communication and the use of many more digital tools (i.e., Survey Monkey, Zoom, email). This method of gathering feedback and engagement will require more small group and one-on-one coaching; it is unclear how well this will work for older adults	• Digital Behavioral Health Literacy will be critical for rolling out to Older Adult population • Remote focus group process is time consuming, but provides critical input to selecting an app • Older Adults are interested in supporting other Older Adults • Older Adults engaged in testing enjoyed the process
Recommendations	• Establish shared guiding principles at the leadership level on how pilots will address language capacity collectively rather than project-by-project. For example, develop shared agreements that the overall project would identify at least x% that respond to Spanish language needs, y% Mandarin, etc. This might prevent some voting against local pilots because one app is not addressing language and approving another because it does address language • View the apps through a lens of language capacity being the top priority; will yield different results than looking at it through the lens of: Does the technology work for the population selected? • Establishing shared agreements and viewing apps through language capacity might better support community buy-in for the project in all communities because it would clarify that Help@Hand is focused first on the technology, but with a commitment to test the language with targeted stakeholder groups where it is most appropriate. It acknowledges the huge language limits existing in current digital behavioral health apps	• Obtaining up front data will be helpful in making a more informed app selection to pilot. App reviewers had diverging opinions about which apps were most helpful. • Learning objectives and differences between the apps – one focused more on increasing sense of belonging and the other on detecting and acknowledging MH symptoms sooner. While there is overlap, each of the apps more clearly addresses one learning objective than the other. This is informative for decision making.

Modoc County	Quarter 1 (Jan–Mar 2020)	Quarter 2 (Apr – Jun 2020)
Tech Lead	• Rhonda Bandy, PhD	• Rhonda Bandy, PhD
Implementation Site	• Modoc County Behavioral Health (MCBH)	• Modoc County Behavioral Health (MCBH)
Team Composition	• MCBH Branch Director, MCBH MHSA Coordinator, Behavioral Health Specialist	• MCBH Branch Director, MCBH MHSA Coordinator, Behavioral Health Specialist
Target Audience	• Current clients • County residents	• Current clients • County residents
Products In Use/ Planned	• DBT Diary Cards from Mindstrong (tentative) • Apps vetted by other Counties that Modoc chooses off the bench (planned)	• Apps vetted by other Counties that Modoc chooses off the bench (planned)
Implementation Approach	• None until apps available on bench • Starting up Appy Hours for Digital Literacy Training in preparation for app implementation	• None until apps available on bench • Appy Hours for Digital Literacy Training on hold due to Covid-19 in preparation for app implementation
Other Unique Qualities (of target audience, implementation, or other program aspect)	• Phones not offered until apps are implemented	• Phones not offered until apps are implemented
Milestone	• Developed Appy Hours	• None this quarter due to Covid-19
Lessons Learned	• Patience – waiting for CalMHSA to finalize contracts, provide budget, get time extension with OAC, and Help@Hand leadership to establish future strategic direction. • Should not have moved into phone contracts; paying every month for phones that are sitting in boxes.	• None, still exercising patience, waiting for apps to be put on bench.
Recommendations	• Make specific effort to keep the Help@Hand collaborative culture between Counties to capture shared learnings	• May try to create implementation poster for Modoc, as Riverside County has done for their County.

Mono County	Quarter 1 (Jan–Mar 2020)	Quarter 2 (Apr – Jun 2020)
Tech Lead	• Amanda Greenberg, MPH • Stephany Valadez	• Amanda Greenberg, MPH • Stephany Valadez
Implementation Site	• TBD	• TBD
Team Composition	• Behavioral Health Program Manager, Behavioral Health Services Coordinator	• Behavioral Health Program Manager, Behavioral Health Services Coordinator
Target Audience	• Individuals in remote, isolated areas of the County who have less access to social support and mental health services • Students attending Cerro Coso Community College in Mammoth Lakes	• Individuals in remote, isolated areas of the County who have less access to social support and mental health services • Students attending Cerro Coso Community College in Mammoth Lakes
Products In Use/ Planned	• TBD (awaiting larger County/City pilots to be completed)	• TBD (awaiting larger County/City pilots to be completed)
Implementation Approach	• TBD (awaiting larger County/City pilots to be completed)	• TBD (awaiting larger County/City pilots to be completed)
Other Unique Qualities (of target audience, implementation, or other program aspect)	• Mono County is very small, remote and rural, so we will have some challenges around implementation in our outlying areas	• Mono County is very small, remote and rural, so we will have some challenges around implementation in our outlying areas
Milestone	• Awaiting pilots	• Awaiting pilots
Lessons Learned	• TBD	• TBD
Recommendations	• TBD	• TBD

Monterey County	Quarter 1 (Jan–Mar 2020)	Quarter 2 (Apr – Jun 2020)
Tech Lead	• Wesley Schweikhard	• Same as Q1
Implementation Site	• Family Member / Friend of an Individual that Experiences a Mental Health Disorder • Individual entering Mental Health Clinic • Community Service Provider conducting outreach activities	• Same as Q1
Team Composition	• Behavioral Health Director, Tech Lead, Subject Matter Experts (Legal, IT)	• Same as Q1
Target Audience	• Adults • Monolingual Spanish adults	• Same as Q1
Products In Use/ Planned	• Custom build behavioral health screening tool (planned)	• Same as Q1
Implementation Approach	• Not Applicable	• Not applicable; Focus is on custom development vendor procurement
Other Unique Qualities (of target audience, implementation, or other program aspect)	• Developing a custom build product instead of an existing product	• Same as Q1
Milestone	• Developed and release Request for Information (RFI) requesting feedback from vendor community on development of peer chat screening tool • Began to analyze RFI results	• Completed analysis of RFI results • Began to develop Request for Proposals (RFP), which was informed by RFI results • Began recruiting RFP review panel to include peers/stakeholders, clinical experts, and technology experts
Lessons Learned		
Recommendations		

Orange County	Quarter 1 (Jan–Mar 2020)	Quarter 2 (Apr – Jun 2020)
Tech Lead	• Sharon Ishikawa, PhD • Flor Yousefian Tehrani, PsyD, LMFT	• Sharon Ishikawa, PhD • Flor Yousefian Tehrani, PsyD, LMFT
Implementation Site	• UCI Medical Center • OC Community Colleges (initial communications begun to explore interest and feasibility of being implementation sites)	• UCI Medical Center • Community Colleges implementation delayed • Re-started conversations with County-operated programs (PACT, esp. CYBH) about MS implementation
Team Composition	• Peer Lead, 2 Peers, Compliance, PIO, AQIS, Cambria (3.5 FTE) to support Mindstrong Launch	• Peer Lead, 2 Peers, Compliance, PIO, AQIS, Cambria (2.5 FTE) to support Mindstrong Launch; 2 HCA INN Staff to support Informed Consent process; re-initiation of discussions with County managers to determine interest in MS (modified model) for their programs
Target Audience	Mindstrong • Adults 18+ • English fluency • Resident of Orange County • Living with Major Depressive Disorder, Bipolar Disorder, Schizophrenia, or Schizoaffective Disorder • May have co-occurring anxiety disorders, substance use disorders or other diagnoses • May have a history of psychiatric hospitalization and/or 1+ crisis evaluations within last 12 months • Device eligibility: owns a smartphone with unlimited data/wi-fi, talk and text • May be expanded depending on research on Lifeline phones and Mindstrong data usage	Mindstrong • Adults 18+ • English fluency • Resident of Orange County • Living with Major Depressive Disorder, Bipolar Disorder, Schizophrenia, or Schizoaffective Disorder • May have co-occurring anxiety disorders, substance use disorders or other diagnoses • May have a history of psychiatric hospitalization and/or 1+ crisis evaluations within last 12 months • Device eligibility: owns a smartphone with unlimited data/wi-fi, talk and text • May be expanded depending on research on Lifeline phones and Mindstrong data usage
Products In Use/ Planned	• Mindstrong Crisis Prevention Services (Planned)	• Mindstrong Crisis Prevention Services (In Use as part of soft launch)
Implementation Approach	• Mindstrong (Not in use yet)	• Mindstrong launched May 14, 2020
Other Unique Qualities (of target audience, implementation, or other program aspect)	• Serving individuals regardless of insurance type/status • Creating plan to pilot/test Lifeline phones • Extensive conversations and iterative refinement around informed consent process involving project team, compliance, Peers, UCI Medical, Mindstrong and video production company; including digitization of consent form and creating companion video/audio	• Proposal for Mobile Innovation and Lifeline Testing going through community planning
Milestone	• Tentative pilot launch at UCI Medical Center in Spring 2020 (depending on impact of COVID-19 public health emergency response)	• Launched Mindstrong with UCI Medical Outpatient Psychiatry on 5/14/2020

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Orange County	Quarter 1 (Jan–Mar 2020)	Quarter 2 (Apr – Jun 2020)
Milestone (continued)	• Implementation planning for Community Colleges, with preliminary soft pilot launch in Fall 2020 (possibly sooner in response to increased need for telehealth support due to impact of COVID-19 on school closures)	• As of June 30, 2020 (end of Q2) UCI MC/Psychiatry referral statistics indicate: o 2 Referring providers o 16 consumers referred o 10 completed Mindstrong enrollments o 4 consumers could not be contacted by HCA-INN to complete Informed consent. o 2 consumers in-process
Lessons Learned	• Shared vision and support from executive leadership is critical to effective planning and implementation • Prioritize system prep, program prep and implementation planning over launching • Involve tech experts in the planning, development and management at the overall collaborative and local level • Communication with vendors, checking in to ensure information, messaging, and shared vision is accurate • Tech vendors should be held to equitable standards • Create a checklist of pre-launch activities (i.e., coordinate meetings w/Compliance, IT, County Counsel, QI) • Ability to course correct, shift/change when needed • Frequently define terms, especially in the beginning, to ensure shared understanding • Collaborate/communicate with the program managers and staff in programs where app will be launched • Obtain feedback from clinicians/Peers early on to assess interest/readiness to use the app services • Continually manage expectations at all levels (i.e., community, programs, vendors) • Risk and Liability workgroup, legal counsel, and crisis response protocols are critical elements to the project • Acknowledge challenges such as managing details with a small team and creating an environment where counties and vendors can openly discuss challenges, concerns and issues • Shared messaging that the Help@Hand project is not about implementing apps, it's about developing a sustainable digital mental health system of care for CA (i.e., infrastructure building) • Apps that involve clinical integration require implementation support staff with clinical experience • With an ever-expanding team, needed to identify strategies for effective communication and decision-making process • Consumers need easy access to County-specific and Help@Hand project information (i.e., website, short codes) • Project needs a grievance process that outlines protocols for the Collaborative's response to complaints/issues • Apps mostly target English-speaking population – cultural adaptations, beyond simple translations of content, are needed to reach and serve diverse communities in a meaningful way	• Refer to Appendix B of this report
Recommendations	• Flow of communication (i.e., within/between/among CalMHSA, counties, vendors) • Plans and frequency of coordinated calls between counties • Status update following the Cambria meetings • Systematic process for testing/vetting apps, including user safety • Process for procuring and demonstrating new apps/vendors, as well as for adding new components to the Suite • Planning, development and implementation process be streamlined and sustainable in the future (i.e., security vetting, compliance, etc.) • Meaning for Counties/Cities to collaborate • Consider risk and liability as part of County planning and readiness • Clinical integration should be the primary focus when planning launch of mental health treatment-focused apps and should include implementation staff with clinical experience • Before engaging program implementation partners, prepare an effective work plan that prioritizes necessary/required preconditions to have in place prior to launch (i.e., roadmap of involved parties and logical order/priorities for IT, data sharing, compliance, clinical integration, etc.)	

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Orange County	Quarter 1 (Jan–Mar 2020)	Quarter 2 (Apr – Jun 2020)
	• Consider use of DARCI model as a strategy for effective and expedited communication and decision-making • Existing Tech is not necessarily geared with the County mental health plan consumer in mind so when exploring and procuring technology, be very clear in including the type of tech the target population will likely have access to, as well as language capabilities (should be included in RFA language, criteria) • OAC updates and reports should provide more information about project and respond directly to request for more information about evaluation (i.e., less discussion about process and specific apps, more emphasis on initially proposed components, lessons learned and steps toward developing a digital mental health system of care) • Develop a collaborative website and include short codes to provide consumers an easy access to project information • Develop a P&P for managing grievance at the collaborative level • Collaborative should develop a cultural adaptation plan; this effort should be led by subject matter experts who develop the specific plan	

Riverside County	Quarter 1 (Jan–Mar 2020)	Quarter 2 (Apr – Jun 2020)
Tech Lead	• Maria Martha Moreno, MS CIS	• Maria Martha Moreno, MS CIS
Implementation Site	• Transitional Age Youth Drop-In Centers (in Mid-County, Desert and Western Regions)	• Riverside County Community, Transitional Age Youth Drop-In Centers (in Mid-County, Desert and Western Regions)
Team Composition	• Peer Manager, Senior Peer, Peers, Clinical Supervisor, CODIE Representative, crisis intervention Clinicians, Application Developer, Technology Lead	• Peer Manager, Senior Peer, Peers, CODIE Representative, crisis intervention Clinicians, Application Developer, Technology Lead
Target Audience	• Higher Risk Populations (i.e., first onset, re-entry, FSP consumers, eating disorders, suicide prevention) • Traditionally Underserved Communities (i.e., Hispanic/Latino, American Indian, African American, Asian-Pacific Islander, LGBTQ, deaf and hard of hearing) • Geographic service barriers to rural and frontier communities • Hearing and visually impaired communities	• Early Detection: TAY • Suicide Prevention: Men over the age of 45, Adults over the age of 65, TAY • Improve Outcomes for High Risk Populations: Re-entry Consumers, FSP Consumers, • Eating Disorder Consumers • Improve Service Access to Underserved Communities and for Rural Regions: Deaf and Hard of Hearing, Visually Impaired, Mid-County & Desert Regions, Ethnic Cultural & LGBT communities.
Products In Use/ Planned	• Take My Hand Peer Chat	• TakemyHand Peer Chat, A4i, Focus, SageSurfer, ManTherapy, FEEL Wearable, custom development for the Deaf and hard of Hearing community.
Implementation Approach	• The Take My Hand site will be live during set hours and managed by trained/certified Peer Operators (COVID-19 response)	• Takemyhand Peer chat is available to the Riverside community and promoted within the department via county emails, committees, social media, newsletters, etc. • Currently planning for focus groups with stakeholders, recruitment of consumers in app pilot selection process with three different Full-Service Partnership clinics (Desert, West and Mid-County regions).
Other Unique Qualities (of target audience, implementation, or other program aspect)	• Piloting own in-house product • Make Peers available on the app 24/7 (Planned) • The peer chat is based on the peer model and people will communicate with a real person; not Artificial Intelligence • Chat is anonymous and does not collect and/or store PII or PHI	• Outreach and Education/Training provided by Peer Manager, Senior Peer, Peers, Supervising CT and Tech Lead. • Regular collaboration feedback/updates to stakeholders committees/Meetings: Adult System of Care Committee; Behavioral Health Commission; Housing Committee; Cultural Competency Reducing Disparities Committee; Older Adults System of Care Committee; Riverside Resilience community; TAY Collaborative – Desert, Mid, and Western; IEHP • Plan to collaborate with: Children's Committee meetings; Criminal Justice Committee; Desert Regional Board; Eating Disorder Collaborative; Inland Empire Kindness Campaign; Mid County Regional Board; Model Deaf Community Committee; NAMI San Jacinto; Promotores; Asian American Task Force; LGBT; PEI Specialized Ethnic Community Initiatives programs

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Riverside County	Quarter 1 (Jan–Mar 2020)	Quarter 2 (Apr – Jun 2020)
Milestone	Compliance: • Terms of Service – Approved by Riverside Help@Hand team (Technical lead, Clinical lead, Peer lead, Senior Peer, Evaluation Supervisor), HIPAA Compliance Officer and County Counsel • Chat engine software (LiveChatInc) approved by County IT, Department IT, HIPAA Compliance Officer, and Executive Team Technical: • Completed chat platform • Accomplished user testing for prototype on two different occasions and feedback was provided • Developed app to be able to identify a crisis situation and transfer chat to CT (a professional with specialized training) • Defined and set useful chat tags for reporting purposes (in various operators groups) • Made site searchable by Google • Made Live Chat Security HIPAA-compliant by disabling the ability to email a chat transcript, the ability to send files (Peer Opera- tor/Visitors), hiding chat history from visitors, inactivity time outs, etc. • Made Operator passwords are managed by Take my Hand site administrators • Made authentication via LiveChat (no IP restriction) • Chat routing manual (visitors are picked from the queue) • Useful Links on Take my Hand website (i.e., Resources, Terms of Service) • Website content is 90 percent complete in English • Website loads testing reports (test 3 response times TakeMy-Hand.com, test 3 transaction throughout TakeMyHand.com) • Creating website content in Spanish (in process) • Cookie Policy (in process) Training: • Developed training materials for Peer Operators (Peer Operator training checklist, training for COVID-19, facilitator's manual for COVID-19, Peer Operator, training PPT script only, print-up manual for Peer Operator COVID-19). This includes a module on strategies to deal with "trolls", inappropriate language and situational challenges from malicious participants. • Scenario role-plays and a brainstorming solution session is included • Provided protocols for risk assessment and crisis protocols (Risk assessment, Questions-to-Assess-Suicide-Risk Handout, Essential Workers Support Line Protocol and Procedure) • Consumer resources; Riverside Free App Brochures (English/Spanish), County Resources (Resources Quick Link on Take my Hand website). • Quick list of crisis phone numbers, MS Teams, email, phone, etc. for internal communications among chat operators • Chat coverage work schedules • Identified protocols for tagging "trolls", inappropriate language chat users, and ability to ban users via the Ban User button • Canned responses • Established work hours • Developed strategy to deal with trolls and visitors using inappropriate language by banning them • Developed pre chat survey, post chat survey, post crisis chat survey, and first time visitors post chat survey Marketing: • Done by word of mouth, via a banner on the department website, and video presentation of product on departments' Facebook, YouTube page, etc. • Have internal department and stakeholders' newsletter (in process) Evaluation: • Developed internal evaluation plan (Evaluation Plan Tech Suite; Surveys (User Survey – post chat survey for participants in English/Spanish, After X number of chats – User Survey (Usability) in English/Spanish, Peer User Operator Survey,	Technical: • Defined and set useful chat tags for reporting purposes (in various Peer Operators groups) • Made TMH website searchable by Google • Management of Peer Operator user accounts and passwords • Authentication via LiveChat (no IP restriction) • Configuration of chat routing manual (visitors are picked from the queue) • Multiple Changes in Pre-Post, crisis and 1st time visitors (English/Spanish) Chat online surveys • Peer Operators TMH groups (Riverside, Riverside Crisis, Riverside 1st time visitors, Riverside Spanish, Riverside Spanish 1st time visitors) setup and configuration • April 27 through May 27, 2020 – Website Visits 94,861, Unique TMH Website Visitors: 2,867 • June 5th through July 5th – Website Visits 63,355, Unique TMH Website Visitors: 2,963. • Website Metrics – need to license the software to be able to report on entire testing period. • Identified technical functionality to tag "troll," inappropriate language chat users, and ability to ban users via the Ban User button • Complexity of the data files Structure of chats statistics files • Create and post Cookie Policy ((English/Spanish) • Notice of Privacy Practices (posted) • Frequently Asked questions webpage • Images management • Website design, development and content management took place as we implemented the test phase. • Website Spanish translations and design of the TakemyHand was implemented three weeks into the testing phase • Define useful Links on Take my Hand website (i.e., Resources, FAQs, Privacy Practices, Terms of Service, About Us, etc.) • Manage website content (English/Spanish) • Design of dynamic widgets (English/Spanish) • Design of content management website tool • TMH Website Load Testing Reports -Response times/Transaction throughout • TMH Capacity Framing –Full scale testing- scales automatically based on volume, performance improved to 1,000 entries requests per second. • 2-Tiers – Chat features in LiveChat engine –AWS/Web hosted Whois. • ELMR setup/training: special population /scheduling calendar site, service codes, staff member hours and exceptions • Export of chat data files: Total chats, Peer Operators Performance, chat duration, chat rating, chat availability, chat engagement, chat response time, missed chats, tags usage, chat waiting time, chat abandonment, pre and post chat surveys for all groups (English/Spanish, 1st time visitors, & crisis) Marketing: • All Hands on Deck Newsletters • ChatVox Weekly Bulletin for Operators • TakemyHand One Page Conversation Handouts for Clinics/Consumers • YouTube TakemyHand Promotional videos o Shannon McCleerey-Hooper: https://youtu.be/UZXfnqoX-2E o Shannon McCleerey-Hooper: https://youtu.be/tb9ilc26oPg o Maria Martha Moreno: https://youtu.be/9Ht94xAPNdc o Pamela Norton: https://losangeles.cbslocal.com/video/program/1430/4540496-website-provides-mental-health-support/ Training: Training Materials were adjusted/improved as the needed. Peer Manager Report share the key players, the steps taken and the lessons learned as Riverside University Health System-Behavioral Health (RUHS-BH) worked to rapidly deploy the test phase of the first, ever, live, one-on-one Peer Support web-based chat platform, in response to the COVID-19 pandemic.

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Riverside County	Quarter 1 (Jan–Mar 2020)	Quarter 2 (Apr – Jun 2020)
Milestone	Clinician Operator Survey, Innovation Demographics in English/ Spanish)	Evaluation: A multi-tiered approach to examine various level of functionality, user experience and impact. The testing phase evaluation will focus on the following goals: 1) Test product acceptance and usability with real chat participants; 2) Gather information on Chat participant experience; 3) Gather information on Peer and CT Operator's Experience and Training
Lessons Learned	• Test, fix and repeat	• Availability of trainers-Changes in Peer and Clinical staff, required ad hoc on-going set up & training • Technical challenges reported with WI-FI reliability –Peer Operator and visitors' end.
Recommendations	• Test, adjust, test and introduce product in phases	• The global pandemic poses unique implementation challenges. A careful planning for virtual activities that are effective in engaging our consumers is essential. Mental health literacy training and pilot apps implementation go hand in hand.

San Francisco County	Quarter 1 (Jan–Mar 2020)	Quarter 2 (Apr – Jun 2020)
Tech Lead	• Teresa Yu, LMFT	• Teresa Yu, LMFT
Implementation Site	• TBD	• TBD
Team Composition	• MHSA Director, Peer, MHSA Program Manager/Tech Lead, MHSA Peer Services Manager, Finance, BHS Consultant, Staff and Director, from MHASF	• MHSA Interim Director (Tech Lead), Peer/MHSA Peer Services Manager, Finance, BHS Consultant, Staff and Director from MHASF
Target Audience	• TBD	• TBD
Products In Use/ Planned	• TBD (waiting on approved apps by the Collaborative) • Headspace (the City/County of SF is exploring to possibly pilot for staff. This would add to the populations included in this project	• TBD (waiting on approved apps by the Collaborative and conducting app exploration)
Implementation Approach	• TBD	• TBD
Other Unique Qualities (of target audience, implementation, or other program aspect)	• Interested in Peer Chat apps available to all, but with a focus on the Transgender and Transitional Age Youth communities	• Interested in Peer Chat apps available to all, but with a focus on the Transgender and Transitional Age Youth communities
Milestone	• Started the City/County's collaboration with Mental Health Association of San Francisco	• Mental Health Association has started to participate in Tech Lead and Implementation calls. They are conducting app exploration.
Lessons Learned	• Contracting with a CBO created challenges as the project is constantly developing. We needed to have a flexible scope of work from the beginning	• Contracting with a CBO created challenges. Passing on information and getting the CBO up to speed took some time.
Recommendations	• Keep lines of communication open	• Regular meetings and communication

San Mateo County	Quarter 1 (Jan–Mar 2020)	Quarter 2 (Apr – Jun 2020)
Tech Lead	• Doris Estremera, MPH	• Doris Estremera, MPH
Implementation Site	• Peninsula Family Service (PFS) • Youth Leadership Institute (YLI)	
Team Composition	• MHSA Coordinator, Peer Specialist/Peer Support, Contracted Agencies: 1) Youth Leadership Institute (TAY Contractor): Peer Lead/ Program Coordinator, Bilingual-bicultural TAY Peer Lead (Spanish), 2) Peninsula Family Services (PFS): Peer Lead/Program Coordi- nator, bilingual-bicultural Peer (Spanish/Chinese)	• MHSA Coordinator, Peer Specialist/Peer Support, Contracted Agencies: 1) Youth Leadership Institute (TAY Contractor): Peer Lead/ Program Coordinator, Bilingual-bicultural TAY Peer Lead (Spanish), 2) Peninsula Family Services (PFS): Peer Lead/ Program Coordi- nator, bilingual-bicultural Peer (Spanish/ Chinese)
Target Audience	• Transitional age youth • Older adults	• Transitional age youth • Older adults
Products In Use/ Planned	• Happify with older adults (planned) • Remente with transitional age youth (planned)	• Headspace for COVID rapid response, plan to release August/ September 2020 Selecting new products, considering: • Unipercare, MyStrength, Wysa for older adults • Headspace, MyStrength, Wysa for transitional age youth
Implementation Approach	• Remente for transitional age youth, YLI Peer Leads and youth ambassadors plan, promote and support the use of the app • Happify for older adults, PFS Peer Leads and older adult ambassadors plan, promote and support use of the app	• Phase 1 – Help@Hand Peer Ambassadors from YLI, PFS and Advisory Committee to promote and support use of all apps (Headspace and additional selections). Peer ambassadors supporting outreach and engagement efforts through appy hours, direct community outreach and additional strategies to be developed. • Phase 2 – California Clubhouse and Heart and Soul (peer-led organizations) Peer Ambassadors to support integration of apps into Behavioral Health and Recovery Services. Strategies to be developed.
Other Unique Qualities (of target audience, implementation, or other program aspect)	• Help@Hand Advisory Committee of local stakeholders meet monthly since inception (provides feedback on technology features, enhancements and customization to meet the needs of older adults and transition age youth, consults on the strategies for outreach and engagement, informs project evaluation questions and outcomes)	• Using T-Mobile Gov L1 Plan to procure devices for clients. • Using Headspace as a broader response to the San Mateo County community at-large to support for one-year due to COVID
Milestone	• Conducted focus groups with older adults and youth to learn needs and select the most appropriate apps • Focus groups to support development of digital mental health literacy curriculum • Hosted NorCal Peer Summit • PFS hosting AppyHours, engaging older adults in using technology • YLI developed a Help@Hand specific Youth Advisory Group • Advisory Committee received training on app exploration process to provide more in-depth input on selected apps • Ambassadors and peers participated in Digital Mental Health Literacy Train-the-trainer	• PFS shifted to over-the-phone and online AppyHours to continue engaging older adults in using technology. • YLI kicked off online Youth Advisory Group • Successfully procured and distributed 40 free phones to clients and tablets for peer workers to support during COVID • In negotiations with Headspace to provide access to the app for one-year to San Mateo County residents as a response to COVID • Re-started app selection process due to Happify unavailability during COVID and youth needs shifting now that interactions are primarily online. • Worked with UCI to tailor the app selection survey and make it available online
Lessons Learned	• Identifying the primary purpose for the use of the app as 1) a support service for clients within the system of care and/or 2) a prevention, linkage and wellness approach for communities is key; the implementation approach for each is completely different • Engage communities early to address digital literacy and support adoption of products later on • Having explicit communication of “non-negotiables” should be part of the selection of an app • Cultural and language vetting should be part of the early focus groups to inform selection of an app • Implement an advisory committee of stakeholders early in the process to vet, consult with, create buy-in and provide direction	• Access to technology supports (devices, training) is a legiti- mate barrier and must be part of the solutions we offer along with the apps • Needs change and the solutions we offer have to change accordingly
Recommendations	• Include evaluation lens as part of project planning and process development for all aspects of the project including procurement, selection, piloting and implementation	• Include devices and digital literacy as part of the overall solution

Santa Barbara County	Quarter 1 (Jan–Mar 2020)	Quarter 2 (Apr – Jun 2020)
Tech Lead	• Lindsay Walter, JD MHSA Chief • Maria Arteaga, JD Peer Manager • Vanessa Ramos- Tech/Peer Lead	• Lindsay Walter, JD MHSA Chief • Maria Arteaga, JD Ethnic and Peer Manager • Vanessa Ramos- Tech/Peer Lead
Implementation Site	• TBD	• On-line for Q2
Team Composition	• MHSA Chief, Department Peer and Equity Services Manager, Assistant Director, County IT staff, Project Manager, Division Chief of IT, MHSA Coordinator, Regional Tech Ambassadors, Tech-Testers	• Assistant Director; Ethnic Services and Peer Manager; MHSA Chief; Health Care Coordinator- Tech/Peer lead; IT; Help@ Hand peer team; Project Contractor
Target Audience	• Individuals age 16 and over living in geographically isolated communities of diverse backgrounds • Transitional aged youth who are students at colleges and universities • Adults discharged from psychiatric hospitals and/or recipients of crisis services	• Individuals age 16 and over living in geographically isolated communities of diverse backgrounds • Transitional aged youth who are students at colleges and universities • Adults discharged from psychiatric hospitals and/or recipients of crisis services
Products In Use/ Planned	• Headspace (planned) • Digital Literacy - Needs and Responses from Stakeholder Sessions (planned) • Digital Mental Health Literacy Course from CalMHSA (planned)	• Digital Wellness Ambassadors curriculum- combined digital literacy (Help@Hand/Painted Brain/CalMHSA) • Zoom platform • App Brochure-mobile application in the brochure
Implementation Approach	• Headspace with up to 45 people which will include Dept. Clinical Staff/IT Staff/Peer Staff/Tech Testers within each target population/CBO that work with target populations/ MHSA Chief/Peer and Equity Manager/Help@Hand Project Manager/if hired by then Help@Hand Project Outreach Coordinator	• Combine digital literacy to create Digital Wellness Ambassadors materials • Disseminate by providing literacy curriculum throughout clinics; community centers; community-based organizations; adult housing; recovery learning centers; on-line; tbd • Share and provide linkage to low cost laptops/phone and WIFI
Other Unique Qualities (of target audience, implementation, or other program aspect)	• Foster diversity within target populations including Spanish/ Mixteco speakers and individuals from communities marginalized including LGBTQ+ • Goals for the pilot include adoption of digital wellness tools within the target populations, reduce isolation and loneliness within target populations, reduce negative life events among members of each target population, implementation of digital literacy and mental health literacy facilitated through peer employment opportunities and measuring the success of wellness through employment	• Peer driven curriculum is created to meet specific needs of peer community within SB target populations • COVID highlighted the need for technology access within target populations; project will begin to explore low cost laptop within target populations; • The group coordinated a digital Mental Health COVID-19 Campaign to compliment the May Mental Health Awareness including daily motivations and resources for all MH Staff, daily peer groups for community and disclosed peers, and targeted age groups by postcard mailings and chalk art. This was then extended by local peer support partners coordinating zoom daily peer groups whose monthly calendar is sent out digitally by our PIO.
Milestone	• Employment of peers • Engagement with peer agencies • Development of strategies for upcoming pilot • Solidified the need for Digital Literacy and Digital Mental Health Literacy throughout the community • Explored digital wellness tools within the Psychiatric Health Facility connecting to the ongoing Wellness and Recovery Peer-run groups • Identified the need for target population of baseline data	• Help@Hand peers are now hired through county extra-help vs temp agency • Contracted with Painted Brain • Began on-line learning collaboratives with painted brain and Help@Hand peers
Lessons Learned	• Target populations need access to digital mental health applications to support their recovery • Awareness of the lack of accessibility of Digital Literacy and Digital Mental Health Literacy throughout the community • Target populations need technological devices linkage (i.e., smartphone, tablets, etc.) • Target populations need culturally- and linguistically-oriented digital literacy workshops to help merge the learning gaps within technology (Digital Equity) • Creation of outreach materials within the Spanish speaking community, especially in isolated communities (Guadalupe and Cuyama area) are needed to increase digital mental health awareness	• COVID highlighted the need for access to technology, primarily laptops – project was dependent on the availability of tech access through public libraries, colleges, and recovery learning centers – all locations are closed until further notice; people do not have access to technology • Peer practices need to be understood throughout all levels of project from end users to management
Recommendations	• Begin technology adaptation with low risk app • Increase programming on Digital Literacy throughout community and clinics • Increase programming with peer organizations surrounding technology use as requested by stakeholders	• Use tech dollars to purchase low cost laptops and start up WIFI for target populations • Adopt ZOOM as selected tech app • Reprioritize tech suite dollars to meet needs brought about with COVID • Understand and train using peer practices throughout project from end user to management

Tehama County	Quarter 1 (Jan–Mar 2020)	Quarter 2 (Apr – Jun 2020)
Tech Lead	• Michelle Brousseau • Avery Vilche	• Travis Lyon • Avery Vilche
Implementation Site	• TBD	• Tehama County
Team Composition	• MHSA Coordinator, Tech Leads, Peer, Behavioral Health Director, Staff	• Behavioral Health Director, MHSA Coordinator, Tech Leads, Peer Supervisor, Staff, Peer Advocates
Target Audience	• TBD	• Persons who are Homeless or at risk of Homelessness, Geographically Isolated Adults, and TCHSA-BH Consumers
Products In Use/ Planned	• TBD	• myStrength
Implementation Approach	• TBD	• Pilot with 30 people (10 from each Target Audience), Track Progress
Other Unique Qualities (of target audience, implementation, or other program aspect)	• TBD	• TBD
Milestone	• Not applicable	• Not applicable
Lessons Learned	• Not applicable	• Not applicable
Recommendations	• Not applicable	• Not applicable

Tri-City	Quarter 1 (Jan–Mar 2020)	Quarter 2 (Apr – Jun 2020)
Tech Lead	• Toni Robinson • Dana Barford	• Toni Robinson • Dana Barford
Implementation Site	• Transitional Age Youth Wellness Center	• Tri-City Wellness Center
Team Composition	• MHSA Coordinator, MHSA Manager, Peer Lead, MHSA Director	• MHSA Manager, MHSA Coordinator, Wellness Advocate Supervisor, Wellness Advocates, Wellness Center Supervisor, Clinicians, MHSA Director, Clinical Director
Target Audience	• Transitional age youth • Older adults • Monolingual Spanish speakers	• For the potential pilot, our target audience has been updated to include: TAY; Older adults; Wellness advocates (peers); FSP clients being monitored by their clinicians
Products In Use/ Planned	• Wysa with transitional age youth	• Wysa
Implementation Approach	• Have a small focus group for pilot to obtain valuable feed-back on a biweekly basis	• Twenty users will be recruited to use Wysa for 3 months and will participate in 7 focus groups held biweekly to evaluate Wysa's usability and effectiveness.
Other Unique Qualities (of target audience, implementation, or other program aspect)	• Having input from a focus group of peers to select the app to be piloted	• A group of 4 clinicians will also be recruited to determine the feasibility and appropriateness of using Wysa in support of the services they provide.
Milestone	• Focus group selected the app for pilot	April • A focus group comprised of Wellness Advocates, MHSA staff, and the IT consultant, participated in a product testing of the Wysa application • Product testing resulted in Tri-City moving forward with the app, with adjustments to the emergency contact function May • Wysa agreed to making adjustments to the emergency contact function of the app • CalMHSA began contract negotiations with Wysa • Tri-City started drafting the pilot proposal • Through the collaboration, various wellness apps have made accessing their apps free for participating counties/agencies and Tri-City has been taking advantage of the opportunity by providing the resources to staff and clients • CalMHSA created Digital Mental Health Literacy training videos and Tri-City will be utilizing the videos for clients and community members

Continued on next page

Tri-City County	Quarter 1 (Jan–Mar 2020)	Quarter 2 (Apr – Jun 2020)
		• Tri-City met with UCI to develop an evaluation plan for the pilot process June • CalMHSA and Wysa reached an agreement in contract negotiations and Tri-City was given the green light to move forward with the pilot proposal and pilot evaluation plan • Tri-City continued to send useful wellness app information to our staff for self-care (and some client resources) • Tri-City Wellness Advocates started planning for a Community Connections webinar to teach our clients and community members how to be safe online. They will be using the skills and information they acquired during the train-the-trainer session of the February Help@Hand Peer Summit • Tri-City was trained to use Smartsheet for project management
Lessons Learned	• Do not look for one app that covers all of the target population, this is a suite of technology (one app will not cover all)	• The project was still able to move forward during safer-at-home orders • Thoroughly go through the OCM plan and make certain that all the parties involved are advocates of the project • App developers are not accustomed to operating with government contract
Recommendations	• None at this time	• Continuously update all parties on the project status • Allow additional time for contract negation with developers who have not previously worked with government entities

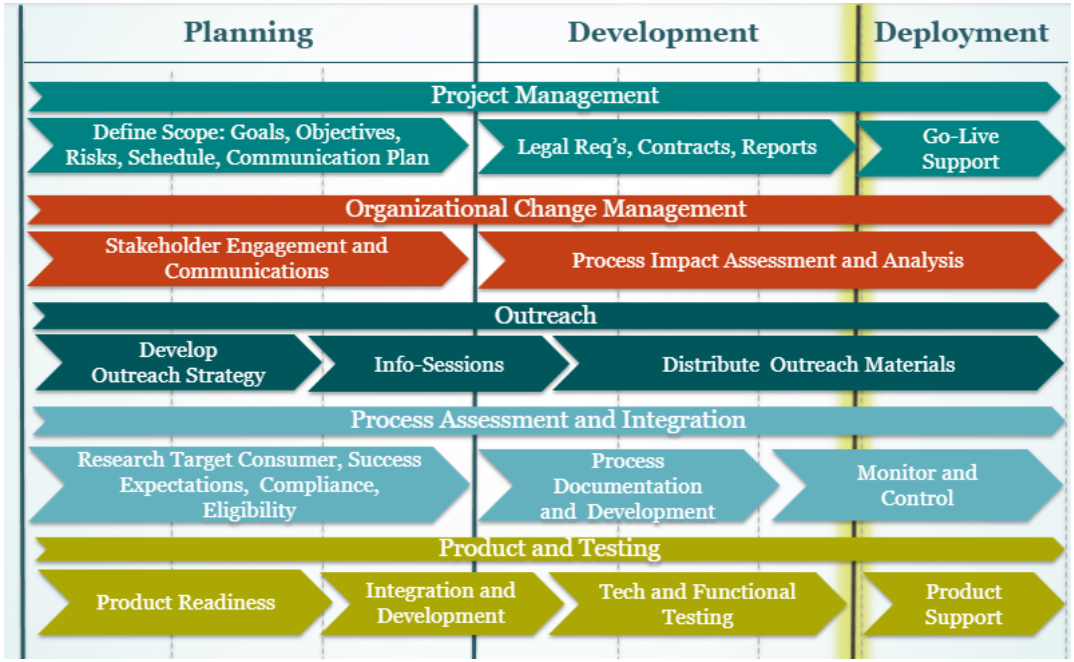
Orange County Health Care Agency Mindstrong Implementation

Lessons Learned Q2 (March 2020 – June 2020)

Introduction

This document includes input from the project team as to what went well, what issues arose during the Orange County Healthcare Agency's Mindstrong Implementation project in the initial launch site (UCI Psychiatry), and recommendations to mitigate those issues. Lessons learned were captured at various intervals throughout the second quarter of 2020 and are categorized within three project phases and five project workstreams, which are graphically represented here and defined below.

Project Timeline and Workstreams



Orange County Health Care Agency
Mindstrong Implementation

Project phases include:

- **Planning phase:** Development of project plans to include schedule, strategy, communication, and change management. Documenting project scope to include project requirements, objectives, deliverables, and exclusions. Documenting processes and risk mitigation plans.
- **Development phase:** Development of future state documents and builds. Creation of outreach materials. Project participant training, and execution of contracts and agreements.
- **Deployment phase:** Product launch/Go-live and implementation of new processes. Conduct stabilization support and monitor launch for optimization opportunities.

Project workstreams include:

- **Project Management:** Management of project activities and documentation to support achievement of project goals.
- **Organizational Change Management (OCM):** Management of activities that support change impact caused by the project.
- **Outreach:** Activities and materials delivering key messages that support project success. Materials are tailored to intended audience (i.e., referring providers, potential consumers, etc.)
- **Process Assessment and Integration:** Activities that support the incorporation of Mindstrong services into the partnering organization's operations processes, clinical processes and systems.
- **Product and Testing:** Activities that are related to the Mindstrong product and product feasibility to target consumers.
- **Evaluation:** Data collection to evaluate the impact and effectiveness of implementation activities and/or performance outcomes.

Lessons Learned Table

ID	Project Phase	Workstream	Topic	Description	Recommendation
1	Development	Process Assessment and Integration	Defining Eligibility	• Eligibility drives which target audience is most relevant. Identify eligibility as soon as possible.	• Involve all relevant parties at project onset to identify key issues that are relevant to eligibility.
2	Planning	Process Assessment and Integration	Documentation Requirements	• Implementation time may be extended when county and legal documentation requirements are not defined.	• Identify county and legal document and consenting requirements for all proposed future-state processes/workflows during the project's planning phase.
3	Planning	Evaluation	Data sharing	• Scope of evaluation depends on nature/type of data provided by vendor, data sharing agreement in place between evaluator and vendor	• Set up DUA/BAA to allow for sharing of PHI/PII data • Know what your LO's are and how you want to evaluate, and then work with vendor on agreement to provide data to support the evaluation; LO's may need to be adjusted based on data available. Continue to re-evaluate impact on ability to evaluate as product/implementation changes over time and adjust

ID	Project Phase	Workstream	Topic	Description	Recommendation
					data sharing and/or evaluation accordingly.
4	Development	Process Assessment and Integration; OCM	Consenting Process	• Lengthy consent document or complex/technical language may discourage consumers from fully reading the document.	• To mitigate these concerns, extensive care and attention was paid to the language and methodology used and concepts covered in the informed consent. Involved Peers, program, Privacy/Compliance and Tech Leads, Mindstrong at each iteration of the form. At present, consumers appear to be responding well to the IC process developed, although UCI will be conducting consumer interviews as part of process evaluation. • Based on interview results and other feedback, explore opportunities to embed new processes in existing processes and technology.
5	Development	Process Assessment and Integration; OCM	Defining Terminology	• Application vendor's and partnering organizations' terminology differs from each other, which affects process and activity	• Define and agree to project nomenclature and terminology during project initiation. • Keep revisiting

ID	Project Phase	Workstream	Topic	Description	Recommendation
				understanding.	
6	Development	Project Management; Process Assessment and Integration; OCM; Outreach	COVID Adjustments	• COVID shifted the interaction from in person to virtual: • All outreach materials need to be adjusted for digital use. • Ease of online access was vital to consumers who needed to access the information. • Consenting process required a digital informed consent in order to reach the consumer. • Consumers could no longer be given support in the lobby for the consenting process.	• Convert all outreach materials to digital-friendly format and have them be digitally available through the website. • Create a short code for consumers to access information links from their smartphones. • Provide remote support to enhance consumer understanding of informed consent and obtain/document their verbal consent in lieu of a signature. • Develop a website that restricts access so that only the intended audience can access information (ex: informed consent) • Include a section in the website with other services the county offers (such as COVID support)
7	Planning	Product and Testing	Technology Access	• Expansion assessment may identify difficulty in reaching a broader consumer base because of their lack of access to	• Test Lifeline devices to verify that eligible Lifeline devices can support the technology. • Explore ways to address wifi/data access

ID	Project Phase	Workstream	Topic	Description	Recommendation
				smartphone devices and/or private wifi/unlimited data	
8	Planning	Product and Testing; OCM	Linguistic and Cultural Adaptation	• The Mindstrong application is currently available to English speakers only.	• Short-term solution: A 24/7 translation service line may be leveraged by Mindstrong in an event they are supporting someone experiencing a crisis and they must speak to someone (family member, roommate, etc) who does not speak English as their preferred language. • Long-term solution: Work with vendor to support, in a culturally and linguistically responsive way, consumers whose preferred language is not English or who come from cultural groups with specific needs; adaptations may include translation/multi-language within the app and/or training of Mindstrong clinicians
9	Planning	Process Assessment and Integration	KPI Tracking	• In order to track the progress of the project, primary KPIs should be identified early in the project, doing so in the	• Consult with the Evaluation team to identify KPIs in the planning phase.

ID	Project Phase	Workstream	Topic	Description	Recommendation
				deployment phase impacted the efficiency of tracking.	
10	Planning	Project Management; Process Assessment and Integration	Referral Tracking and Reporting	• Data reporting elements and tracking format should be identified during the planning phase, doing so in the deployment may create delays in producing reporting.	• Data should be tracked in a discrete manner and minimal free form text to allow for ease of analysis.
11	Deployment	Process Assessment and Integration	Referral and Enrollment Statistics	• Reporting format should suit the audience requirements appropriately.	• As a part of go-live planning each audience and reporting requirements should be clearly defined resulting in an optimal reporting format.
12	Deployment	Project Management	Expansion	• Requirements for deployment expansion are needed in order to advance the project.	• Prior to go-live, identify milestones and objectives be met. Evaluate each milestone and objective to evaluate readiness.
13	Deployment	Process Assessment and Integration; OCM	Adoption Rate	• It is important to understand reasons consumers might not engage with Mindstrong services.	• Engage all relevant parties in assessment and tracking of consumer feedback.

APPENDIX C: LIST OF LANGUAGES AVAILABLE IN APPS REVIEWED FOR MARKET SURVEILLANCE

Table 10. Presents the languages available in the apps reviewed for the market surveillance.

App name	Languages (iOS)	Languages (Android)
365 Gratitude Journal	English	English
7 Cups	English, Afrikaans, Arabic, Catalan, Croatian, Czech, Danish, Dutch, Finnish, French, German, Greek, Hebrew, Hungarian, Indonesian, Italian, Japanese, Korean, Malay, Norwegian Bokmål, Polish, Portuguese, Romanian, Russian, Simplified Chinese, Slovak, Spanish, Swedish, Thai, Traditional Chinese, Turkish, Ukrainian, Vietnamese	English, Afrikaans, Arabic, Catalan, Croatian, Czech, Danish, Dutch, Finnish, French, German, Greek, Hebrew, Hungarian, Indonesian, Italian, Japanese, Korean, Malay, Norwegian Bokmål, Polish, Portuguese, Romanian, Russian, Simplified Chinese, Slovak, Spanish, Swedish, Thai, Traditional Chinese, Turkish, Ukrainian, Vietnamese
DBT Coach	English	English
Habitica	English, Bulgarian, Chinese, Croatian, Czech, Danish, Dutch, French, German, Hebrew, Italian, Japanese, Mandarin, Polish, Portuguese, Romanian, Russian, Simplified Chinese, Spanish	English, Bulgarian, Chinese, Croatian, Czech, Danish, Dutch, French, German, Hebrew, Italian, Japanese, Mandarin, Polish, Portuguese, Romanian, Russian, Simplified Chinese, Spanish
iPrevail	English	English
iRel8	English	English
LGBT+ Amino	English, Arabic, French, German, Korean, Portuguese, Russian, Simplified Chinese, Spanish	English
OOTify	English	English
Pocket Rehab	English	English
rTribe	English	English
Sanvello	English	English and text translations in Spanish, & French
Sober Grid	English	English
SoberTool	English	English
Solace	English	English
TalkLife	English	English
Therapeer	English	English
Trill Project	English	English
Unmasked Mental Health	English	English
Wakie	English, Arabic, Japanese, Russian, Thai	English
We Are More	English	English
What's Up	English	English
Wisdo	English	English

APPENDIX D: FREE APPS TO HELP PEOPLE COPE WITH COVID-19

FREE APPS TO HELP PEOPLE COPE WITH COVID-19 June 2020

This review highlights well-established and popular free apps to help people cope with COVID-19. These apps have either made existing content available for free during the pandemic, or added new content to address issues arising from COVID-19.

App Name / Developer	Platform: iOS	Platform: Android	Platform: Web	Cost: Completely Free	Cost: Free, with additional features available in paid version	Intervention Components: CBT	Intervention Components: Positive Psychology	Intervention Components: Mindfulness	Intervention Components: Chatbot/AI	Intervention Components: Symptom Tracking	Intervention Components: Psychoeducation	Available Languages	Population-Specific Tailored Content	Available COVID-19 Specific Content	Year Launched	# of Downloads (in past 90 days): iOS	# of Downloads (in past 90 days): Android	Published Research Evidence	Vetted in Help@Hand RFSQ?
Calm Calm, Inc.	•	•	•		•		•	•				English, German, Spanish, French, Korean, Portuguese	Children	Free resource hub online: https://www.calm.com/blog/take-a-deep-breath	2013	2,279,000	2,272,000	Yes	No
COVID Coach National Center for PTSD	•	•		•		•	•	•		•	•	English	Some resources for military personnel & parents/caregivers	App created for COVID-19 & draws from another app by same developers	2020	16,920	9,412	No	No
Happify Happify, Inc.	•	•	•		•	•	•	•		•	•	English, Chinese, French, German, Japanese, Portuguese, Spanish, Traditional Chinese	None	Has content such as "Managing Stress in Uncertain Times"	2013	30,290	9,125	Yes	Yes
Headspace* Headspace Inc.	•	•	•		•		•	•				English, French, German, Portuguese, Spanish	Children	COVID-19 "Weathering the storm" content pack free for everyone. Premium access is free to the unemployed, health professionals, & educators during pandemic	2012	860,200	851,200	Yes	Yes
NOD Grit Digital Health	•	•		•		•	•	•				English	College students & young people	App redesigned for COVID-19 & has activities for social distancing	2019	1,108	738	No**	Yes
Sanvello* Sanvello Health Inc.	•	•	•		•	•		•		•	•	English, text translations in Spanish & French	None	Has community discussion groups specific to the pandemic. Premium access is free during pandemic	2012	63,020	254,800	Yes	No
SuperBetter SuperBetter, LLC	•	•	•	•		•	•				•	English	None	Two new COVID-19 specific content ("Stay Strong in a Pandemic" & "Stay-at-Home Scavenger Hunt")	2012	10,030	3514	Yes	No
This Way Up St Vincent's Hospital Sydney			•	•		•				•	•	English	Teenagers, young adults, & adults	Guided downloadable workbooks & resources ("Staying on Track During the Pandemic")	2012	N/A – Web app	N/A – Web app	Yes	No
Woebot Woebot Labs, Inc.	•	•		•		•			•	•	•	English	Young adults	Additional COVID-19 lesson ("Perspective")	2018	23,760	115,800	Yes	No
Wysa * Wysa Ltd.	•	•			•	•		•	•	•	•	English	None	Has health anxiety & isolation content free to anyone during pandemic	2016	30,450	45,770	Yes	Yes

* Apps included in Catalyst toolkit located at: https://georgehills.sharepoint.com/sites/helpathand/_layouts/15/Doc.aspx?sourcedoc=%7B0CC8FF8F-DF56-46D2-8718-4D0A452F3AAA%7D&file=COVID%2019%20Resources.docx&action=default&mobileredirect=true

** Randomized control trial completed, but not yet published

help @ hand™ Evaluation

For questions or feedback, please contact:
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