MENTAL HEALTH SERVICES ACT
FY 19-20 PLAN UPDATE

MENTAL HEALTH SERVICES ACT

ALAMEDA COUNTY

FY 2019 - 2020

ANNUAL PLAN UPDATE

RELEASED FOR PUBLIC COMMENT: DECEMBER 11, 2019 – JANUARY 13, 2020
Public Hearing: January 13th, 2020
Alameda County Mental Health Advisory Board, 3pm San Leandro*

*Please Note: A presentation on the FY 2019-2020 Plan Update will take place during the Mental Health Advisory Board meeting between 3 and 5pm. The public hearing to close out the 30 day public comment period for this Plan Update will take place at 500 Davis St., San Leandro at 5:15.

SEND YOUR PUBLIC COMMENTS TO: mhsa@acgov.org

TABLE OF CONTENTS

1. Message from the Agency Director	Pg. 1
2. MHSA Funding Summary	Pg. 2-7
3. Summary of Changes from FY 18-19	Pg. 8-14
4. Alameda County Demographics	Pg. 15-23
A. COMMUNITY SERVICES & SUPPORTS (CSS) PROGRAM SUMMARIES	**Pg. 24-156**
Full Service Partnership (FSP) Programs	**Pg. 29-62**
FSP 3 Supportive Services for TAY (STAY)	Pg. 29-31
FSP 4 Greater HOPE Project	Pg. 32-34
FSP 10 Housing Solutions for Health	Pg. 35-37
FSP 11 Community Conservatorship (CC) Program	Pg. 38 & 39
FSP 12 Assisted Outpatient Treatment (AOT) Program	Pg. 40 & 41
FSP 13 CHANGES	Pg. 42-44
FSP 14 STRIDES	Pg. 45 & 46
FSP 16 Alameda Connections	Pg. 47-49
FSP 17 East Bay Wrap	Pg. 50 & 51
FSP 18 Homeless Engagement Action Team (HEAT)	Pg. 52 & 53
FSP 19 Circa60	Pg. 54 & 55
FSP 20 Lasting Independence Forensic Team (LIFT)	Pg. 56 & 57
FSP 21 Prevention, Advocacy, Innovation, Growth & Empowerment (PAIGE)	Pg. 58 & 59
FSP 22 Justice and Mental Health Recovery (JAMHR)	Pg. 60-62
Outreach Engagement System Development (OESD) Programs	**Pg. 63-156**
OESD 4A Mobile Integrated Assessment Team for Seniors	Pg. 63-65
OESD 5A Crisis Response Programs: South County, MCT & MET	Pg. 66-68
OESD 7 Behavioral Health Court	Pg. 69 & 70
OESD 7 Court Advocacy Project (CAP)	Pg. 71-73
OESD 8 Juvenile Justice Transformation of Guidance Clinic	Pg. 74-76
OESD 9 Multi-Systemic Therapy (MST)	Pg. 77 & 78
OESD 11 Crisis Stabilization Unit (CSU): Willow Rock	Pg. 79 & 80
OESD 14 Language ACCESS Asian	Pg. 81-85
OESD 15 ACCESS Staffing to Latino Population	Pg. 86-88
OESD 17 Residential Treatment for Co-occurring Disorders- Cronin House	Pg. 89 & 90
OESD 17 Residential Treatment for Co-occurring Disorders- Chrysalis	Pg. 91 & 92
OESD 18 Wellness Centers: BACS	Pg. 93 & 94
OESD 18 Wellness Centers: Bonita House	Pg. 95 & 96
OESD 18 Wellness Centers: Network of ACNMHC	Pg. 97 & 98
OESD 19 Pathways to Wellness Medication Clinic	Pg. 99-101
OESD 19 Medication Support Services: Short-term Case Management Services	Pg. 102 & 103
OESD 20 Individual Placement Services (IPS)	Pg. 104-107

OESD 22 African American Wellness Hub Complex Planning Phase Pg. 108
OESD 23 Crisis Residential Services Pg. 109 &110
OESD 24 Schreiber Center Pg. 111 & 112
OESD 25 Behavioral Health - Primary Care Integration Project (Fremont PATH) Pg. 113 & 114
OESD 25 Behavioral Health - Primary Care Integration Project (Oakland PATH) Pg. 115 & 116
OESD 25 TRUST Clinic Health Center Pg. 117-119
OESD 26A Training & TA on Accurate/Appropriate Practices for African-Americans Pg. 120-122
OESD 26B Afiyacare Pg. 123-125
OESD 26C MH Wellness Supports at MHSA Housing Sites Pg. 126
OESD 27 In-Home Outreach Team (IHOT): Abode Services Pg. 127-129
OESD 27 In-Home Outreach Team (IHOT): Bonita House Pg. 130 & 131
OESD 27 In-Home Outreach Team (IHOT): La Familia Pg. 132-134
OESD 27 In-Home Outreach Team (IHOT): STARS Pg. 135 & 136
OESD 28 Success At Generating Empowerment (SAGE) Pg. 137 & 138
OESD 29 Older Adult Service Team Pg. 139-142
OESD 30 Sally's Place Peer Respite Pg. 143-145
OESD 31 Felton Early Psychosis Programs: (re)MIND and BEAM Pg. 146-148
OESD 32 Suicide Prevention Crisis Line Pg. 149-153
OESD 33 Deaf Community Counseling Services Pg. 154-156

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES Pg. 157-401

PEI: Prevention **Pg.** 159-297
PEI 1A School-Based MH Consultation in Preschools- Blue Skies Pg. 159-162
Underserved Ethnic Language Population (UELP) Programs Pg. 163-253
PEI 5 Outreach, Education & Consultation (Latino Comm.)- La Clinica Pg. 167-172
PEI 6 Outreach, Education & Consultation (API Comm.)- Asian Health Services Pg. 173-179
PEI 6 Outreach, Education & Consultation (API Comm.)- CERI Pg. 180-189
PEI 6 Outreach, Education & Consultation (API Comm.)- CHAA Pg. 190-195
PEI 6 Outreach, Education & Consultation (API Comm.)- KCCEB Pg. 196-205
PEI 6 Outreach, Education & Consultation (API Comm.)- RAMS Pg. 206-211
PEI 6 Outreach, Education & Consultation (API Comm.)- Tri-City Health Center Pg. 212-216
PEI 7 Outreach, Education & Consultation (So. Asian/Afghan Comm.)- Afghan Well. Pg. 217-222
PEI 7 Outreach, Education & Consultation (So. Asian/Afghan Comm.)- Filipino Well. Pg. 223-228
PEI 7 Outreach, Education & Consultation (So. Asian/Afghan Comm.)- IRC Pg. 229-235
PEI 7 Outreach, Education & Consultation (So. Asian/Afghan Comm.)- Hume Center Pg. 236-241
PEI 8 Outreach, Education & Consultation (Native American Comm.)- NAHC Pg. 242-246
PEI 10 Outreach, Education & Consultation (African Comm.)- PTR Pg. 247-253
PEI 14 Family Education & Resource Center (FERC) Pg. 254-260
PEI 20A Culturally Responsive PEI Programs for African American Comm.- BRL Pg. 261-265
PEI 20D Culturally Responsive PEI Programs for African American Comm.- RJOY Pg. 266-277
PEI 20E Culturally Responsive PEI Programs for African American Comm.- PEERS Pg. 278-283

PEI 21B *Bay Area Community Services (BACS)-* **Program moved to CSS Component, OESD 18**

PEI 23 Mentors on Discharge- Post Crisis Peer Mentoring Pg. 284-289

PEI 24 Sobrante Park Community Project- Roots Comm. Health Center Pg. 290-297

PEI: Early Intervention **Pg. 298-324**

PEI 2 Early Intervention for the Onset of First Psychosis & SMI among TAY Pg. 298-306

PEI 3 Mental Health for Older Adults, Geriatric Assessment & Response Team (GART) Pg. 307-312

PEI 17A TAY Resource Center- Youth Uprising Pg. 313-318

PEI 17B TAY Resource Centers- REACH Ashland Pg. 319-324

PEI: Outreach **Pg. 325-383**

PEI 1C Early Childhood Mental Health Outreach & Consultation Pg. 325-330

PEI 1D Unaccompanied Immigrant Youth Outreach (UIY) Pg. 331-335

PEI 1E School-Based Mental Health Outreach Pg. 336-342

PEI 1F Community-Based Mental Health Outreach & Consultation Pg. 343-349

PEI 13 *Wellness, Recovery and Resiliency Services (Berkeley Drop-in, Best Now, Reaching Across, Reach Out, Tenant Support)-* **Program moved to CSS Component, OESD 18**

PEI 13 Wellness, Recovery & Resiliency Services-WRAP- PEERS Pg. 350-355

PEI 19 Older Adult Peer Support- City of Fremont Pg. 356-361

PEI 20B Culturally Responsive African American Programming- Black Men Speak Pg. 362-366

PEI 20C Culturally Responsive African American Programming- Family Support Pg. 367-371

PEI 22 LGBT Support Services- Older and Out Pg. 372-376

PEI 22 Pacific Center Technical Assistance Program Pg. 377-383

PEI: Access and Linkage **Pg.** 384-390

PEI 1B School-Based Mental Health Access & Linkage in Elementary, Middle & HS Pg. 384-390

PEI 15 *Acute Crisis Care and Evaluation for System-Wide Services (ACCESS) Staffing for Asian population-* **Program moved to CSS Component, OESD 14**

PEI 16 *Acute Crisis Care and Evaluation for System-Wide Services (ACCESS) Staffing for Latino population-* **Program moved to CSS Component, OESD 15**

PEI: Stigma and Discrimination Reduction Programs **Pg.** 391-396

PEI 4 Stigma & Discrimination Reduction Campaign- “Everyone Counts” PEERS Pg. 391-396

PEI: Suicide Prevention **Pg. 397-401**

PEI 12 Suicide Prevention- Crisis Support Services Suicide Prevention Text Line Pg. 397-401

C. INNOVATIVE (INN) PROGRAM SUMMARIES **Pg. 402-407**

Summary of Changes

1. **INN Programs Under Approval Process** Pg. 402 & 403
   - A. Funding for Community Planning Process And Stakeholder Input
   - B. Transitional Age Youth (TAY) Emotional Emancipation Circles (EEC)
2. **Previously Approved INN Programs Under Development- Future Procurement** Pg. 403
   - A. Supportive Housing Land Alliance
3. **INN Programs Currently in Progress** Pg. 403-406
   - A. Community Assessment and Transport Team (CATT)

B. Transitional Age Youth Emotional Emancipation Circles

C. Mental Health Technology Applications

4. INN Programs No Longer Under Development Pg. 406

A. Introducing Neuroplasticity to Mental Health Services for Children

B. Cannabis Education Program for Transition Age Youth (TAY) w/Mental Health Challenges

5. New INN Programs under Development for Future Procurement Pg. 406 & 407

6. Innovation Grant Projects Completed Pg. 407

D. WORKFORCE, EDUCATION, & TRAINING (WET) PROGRAM SUMMARIES **Pg. 408-424**

1. Workforce Staffing & Support Pg. 408 & 409
2. Staff Development, Training/Conferences and Consultants Pg. 410 & 411
3. Internship Program and Educational Pathways Pg. 411-416
4. ACBH Training Institute Pg. 417-420
5. Post Graduate Certificate Program Pg. 420 & 421
6. Psychiatry and Integrated Behavioral Health Care Pg. 421
7. Graduate intern Stipend Program Pg. 422
8. Loan Assumption program *(not started/no data)* Pg. 423
9. Consumer and Family Training, Education and Employment Pg.423 & 424
10. MHSA Support & Community Based Learning (CBL) *(new in WET section)* Pg. 424

E. CAPITAL FACILITIES & TECHNOLOGY (CFTN) PROGRAM SUMMARIES **Pg. 425-428**

CFTN Program Summaries Pg. 425-248

APPENDICES **Pg. 429-442**

APPENDIX A.

Funding for Community Planning Process & Stakeholder Input Doc. Pg. 429-433

APPENDIX B.

Workforce Education & Training (WET) Training Report Pg. 434-440

APPENDIX C.

Alameda County 2019 Every One Counts Homeless Point-in-Time Doc. Pg. 441 & 442

DIRECTOR'S MESSAGE

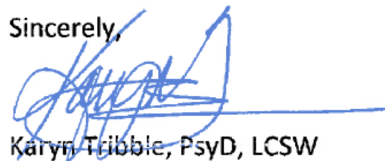
Thank you for your interest in Alameda County's Mental Health Services Act (MHSA) Fiscal Year 2019/2000 (FY 19/20) Plan Update. This is the final year of our current Three Year Plan (FY 2017/18-2019/20) before we head into our next Community Planning Process this coming spring.

This year's Annual Update reports on all MHSA services and activities from FY 2018-19 and reflects our ongoing commitment, we hold with our community partners, to offer integrated services that are client and family-driven, recovery oriented and easily accessible to diverse underserved populations.

This last fiscal year has been full of activity as Alameda County Behavioral Health (ACBH) has focused on a number of new programs such as the opening of our dual crisis stabilization and residential program (*Amber House*) operated by Bay Area Community Services (BACS) and the new *Berkeley Wellness Center*, which is a joint partnership with the city of Berkeley. In addition to these new facilities, ACBH has piloted a school-based project in the Oakland Unified School District where MHSA funds have been combined with other mental health funds to better serve children and youth who have a severe emotional disturbance (SED) so they can better succeed at school and at home.

Housing and homelessness for individuals with severe mental illness continues to be a top priority for ACBH, as well as for Alameda County overall. ACBH is deeply committed to this population and providing a multi-faceted approach to reducing homelessness. Our efforts currently include partnership developments with local community based organizations, increasing the quality of housing support services, increasing the rates of our local board and care facilities, housing navigation services and the implementation of our newly approved Innovation project called the Alameda County Supportive Housing Community Land Alliance.

It's my hope that you find this Annual Update both informative and a reflection of our ACBH vision to *empower all individuals and their families to successfully realize their potential, to pursue their dreams, and to help build a community where stigma and discrimination against those with mental health and/or substance use issues are remnants of the past.* We look forward to advancing these ideals, and the activities and programs listed in this Annual Plan Update.



Director of Alameda County Behavioral Health

FY 2019/20 Mental Health Services Act Annual Update
Funding Summary

County: Alameda | Date: 12/9/19

	MHSA Funding					
	A	B	C	D	E	F
	Community Services and Supports	Prevention and Early Intervention	Innovation	Workforce Education and Training	Capital Facilities and Technological Needs	Prudent Reserve
A. Estimated FY 2019/20 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	44,072,575	0	12,503,386	(0)	7,342,921	
2. Estimated New FY 2019/20 Funding	61,115,750	15,278,938	4,020,773			
3. Transfer in FY 2019/20[a/]	(9,684,326)			3,380,705	6,303,621	
4. Access Local Prudent Reserve in FY 2019/20	17,316,914	4,301,000				(21,617,914)
5. Estimated Available Funding for FY 2019/20	112,820,913	19,579,938	16,524,159	3,380,705	13,646,542	
B. Estimated FY 2019/20 MHSA Expenditures	88,219,948	15,186,598	6,333,164	3,380,705	13,646,542	
G. Estimated FY 2019/20 Unspent Fund Balance	24,600,966	4,393,340	10,190,995	(0)	0	

H. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2019	36,210,952
2. Contributions to the Local Prudent Reserve in FY 2019/20	0
3. Distributions from the Local Prudent Reserve in FY 2019/20	(21,617,914)
4. Estimated Local Prudent Reserve Balance on June 30, 2020	14,593,038

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

		Fiscal Year 2019/20					
		A	B	C	D	E	F
		Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs							
FSP 3	Support Housing for TAY	2,969,073	1,906,768	1,062,305			
FSP 4	Greater Hope Project	4,398,759	2,841,598	1,557,161			
FSP 7	SSI Advocacy & Support Services	2,444,029	2,056,952	387,077			
FSP 10	Housing Services	15,245,050	14,969,028	276,022			
FSP 11	Community Conservatorship Pilot	282,335	282,335	0			
FSP 12	Assisted Outpatient Treatment (AOT) Pilot	988,279	988,279	0			
FSP 13	CHANGES	2,974,107	1,933,170	1,040,937			
FSP 14	STRIDES	2,974,105	1,933,168	1,040,937			
FSP 16	Alameda Connections 0-8	540,525	351,341	189,184			
FSP 17	East Bay Wrap 8-18	735,585	735,585	0			
FSP 18	Homeless Engagement	4,398,760	2,859,194	1,539,566			
FSP 19	No. Co. Senior Homeless	2,905,008	1,888,255	1,016,753			
FSP 20	Lasting Independence Forensic Team	2,969,072	1,929,897	1,039,175			
FSP 21	Prevention, Advocacy, Innovation, Growth, and Empowerment	1,484,534	1,187,627	296,907			
FSP 22	Justice and Mental Health Recovery	4,117,909	3,283,684	834,225			
Non-FSP Programs							
OESD 4A	Mobile Integrated Assess Team for Seniors	625,558	377,962	247,596			
OESD 5A	Crisis Response Program - Capacity for Valley and Tri-City	3,795,089	2,121,879	1,673,210			
OESD 7	MH Court Specialist Program	666,028	345,003	321,025			
OESD 8	Juvenile Justice Transformation of Guidance Clinic	478,451	247,837	230,614			
OESD 9	Multisystemic Therapy	849,104	521,350	327,754			
OESD 11	Crisis Stabilization Service	6,934,021	6,213,364	720,657			
OESD 14	Staffing to Asian Population	1,528,281	963,512	564,769			
OESD 15	Staffing to Latino Population	800,268	523,652	276,616			
OESD 17	Residential Treatment for Co-occurring Disorders	918,044	344,266	573,778			
OESD 18	Wellness Center	7,023,653	5,835,910	1,187,743			
OESD 19	Medication Support Services	2,752,424	1,479,973	1,272,451			
OESD 20	Individual Placement Services	3,522,027	1,904,395	1,617,632			0
OESD 22	Planning African American Wellness Hub Complex	623,520	439,140	184,380			
OESD 23	Crisis Residential Services	1,579,669	857,402	722,267			
OESD 24	Schreiber Center	370,231	240,650	129,581			
OESD 25	Behavioral Health - Primary Care Integration Project	6,671,147	5,197,317	1,473,830			
OESD 26AB	Culturally-Responsive Treatment Programs for African-American C	721,062	468,690	252,372			
OESD 27	In Home Outreach Team	2,824,916	2,341,166	483,750			
OESD 28	SAGE Case & Care Management	2,569,040	1,669,876	899,164			
OESD 29	Older Adult Service Team	1,335,640	868,166	467,474			
OESD 30	Peer Respite	988,503	642,527	345,976			
OESD 31	1st Onset	1,117,417	724,310	393,107			
OESD 32	Suicide Prevention/Crisis Line	941,530	708,302	233,228			
OESD 33	Deaf Community Counseling Services	297,752	193,539	104,213			
OESD 34	School-Based Behavioral Health	1,559,875	1,557,632	2,243			
OESD 35	Community-Based Mental Health Outreach & Consultation	1,793,988	1,758,199	35,789			
OESD 36	Co-Occurring Disorders Program	525,000	525,000	0			
CSS Administration		14,413,382	10,002,046	4,411,336			
CSS MHSA Housing Program Assigned Funds		0					
Total CSS Program Estimated Expenditures		117,652,750	88,219,948	29,432,803	0	0	0
FSP Programs as Percent of Total		56.0%					

MHSA Funding Summary, Prevention and Early Intervention (PEI) Component Worksheet

		Fiscal Year 2019/20					
		A	B	C	D	E	F
		Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention							
PEI 1A	School-Based Mental Health Consultation in Preschools	869,782	775,550	94,232			
PEI 1B	School-Based Mental Health Access & Linkage in Elementary, Middle, & High Schools	1,007,655	1,007,655	0			
PEI 1C	Early Childhood Mental Health Outreach & Consultation	388,900	300,000	88,900			
PEI 1D	Unaccompanied Immigrant Youth Outreach	724,542	655,566	68,976			
PEI 4	Stigma & Discrimination Reduction Campaign	1,307,359	1,296,120	11,239			
PEI 5	Outreach, Education & Consultation for Latino Community	1,277,254	991,813	285,441			
PEI 6	Outreach, Education & Consultation for Asian Pacific Islander Community	2,031,724	1,654,307	377,417			
PEI 7	Outreach, Education & Consultation for South Asian/Afghan Community	1,430,000	1,325,856	104,144			
PEI 8	Outreach, Education & Consultation for Native American Community	290,000	211,990	78,010			
PEI 9	Outreach, Education & Consultation for Middle Eastern Community	290,000	290,000	0			
PEI 10	Outreach, Education & Consultation for African Community	289,901	233,901	56,000			
PEI 12	Suicide Prevention	928,230	902,240	25,990			
PEI 17AB	TAY Resource Centers	895,904	767,376	128,528			
PEI 19	Older Adult Peer Support	279,724	279,724	0			
PEI 20A-E	Culturally Responsive PEI programs for the African American Community	1,192,352	1,190,746	1,606			
PEI 22	LGBT Support Services	331,815	331,815	0			
PEI 24	Sobrante Park Project	350,000	350,000	0			
PEI 25	Trauma Informed Systems (TIS) Training	49,850	49,850	0			
PEI Programs - Early Intervention							
PEI 3	Mental Health for Older Adults, Geriatric Assessment & Response (GART) Team	927,902	659,431	268,471			
PEI Administration		2,210,330	1,912,659	297,671			
PEI Assigned Funds		0					
Total PEI Program Estimated Expenditures		17,073,224	15,186,598	1,886,626	0	0	0

MHSA Funding Summary, Innovation (INN) Component Worksheet

		Fiscal Year 2019/20					
		A	B	C	D	E	F
		Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs							
1.	Community Assessment & Transport Team (CATT)	2,089,554	2,089,554				
2.	TAY EEC	150,000	150,000				
3.	Land Trust	1,200,000	1,200,000				
4.	MH Technology Project 2.0 (MH Apps)	2,241,021	2,241,021				
5.		0					
6.		0					
7.		0					
8.		0					
9.		0					
10.		0					
11.		0					
12.		0					
13.		0					
14.		0					
15.		0					
16.		0					
17.		0					
18.		0					
19.		0					
20.		0					
INN Administration		702,640	652,589	50,051			
Total INN Program Estimated Expenditures		6,383,215	6,333,164	50,051	0	0	0

MHSA Funding Summary, Workforce, Education and Training (WET) Component Worksheet

		Fiscal Year 2019/20					
		A	B	C	D	E	F
		Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs							
1.	Workforce Staffing & Support	688,794	482,156	206,638			
2.	Staff Development, Training/Conference and Consultants	60,000	60,000				
3.	Graduate Student Internship/Educational Pathways Programs	51,500	51,500				
4.	ACBH Training Institute	869,141	869,141				
5.	Post Graduate Certificate Program	227,805	227,805				
6.	Psychiatry and Integrated Behavioral Health Care	179,400	179,400				
7.	Graduate Intern Stipend Program	125,000	125,000				
8.	Loan Assumption Program (not started)	500,000	500,000				
9.	Consumer and Family Training, Education & Employment	497,762	497,762				
10.	MHSA Support and Public Education Campaign & CBL	387,941	387,941				
11.		0					
12.		0					
13.		0					
14.		0					
15.		0					
16.		0					
17.		0					
18.		0					
19.		0					
20.		0					
WET Administration		0					
Total WET Program Estimated Expenditures		3,587,343	3,380,705	206,638	0	0	0

MHSA Funding Summary, Capital Facilities/Technological Needs (CFTN) Component Worksheet

		Fiscal Year 2019/20					
		A	B	C	D	E	F
		Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Program - Capital Facilities Projects							
1.	Crisis Residential Treatment & Stabilization Unit	2,425,000	2,425,000				
2.	South County Homeless Project	240,159	240,159				
3.	Alameda Point Collaborative	1,000,000	1,000,000				
4.	Sonoma Street Parking Lot	365,000	365,000				
5.	Respite Bed Expansion	3,000,000	3,000,000				
6.	County Facility Renovation	1,767,302	1,767,302				
7.		0					
8.		0					
9.		0					
10.		0					
CFTN Program - Technological Needs Projects							
11.	Behavioral Health Management System	321,911	321,911				
12.	Web-based dashboard	97,000	97,000				
13.	County Equipment & Software Update	497,027	497,027				
14.	Information System Infastructure	2,911,000	2,911,000				
15.	Consulting Services	220,000	220,000				
16.		0					
17.		0					
18.		0					
19.		0					
20.		0					
CFTN Administration		1,145,919	802,143	343,775			
Total CFTN Program Estimated Expenditures		13,990,317	13,646,542	343,775	0	0	0

SUMMARY OF CHANGES FROM PREVIOUS PLAN (FY 18/19)

Alameda County Behavioral Healthcare Services (ACBH) began implementation of its MHSA Plan upon receiving approval of our Community Services & Supports (CSS) component plan from the California Department of Mental Health in 2007. Subsequently, ACBH received approval of four additional component plans: Prevention & Early Intervention (PEI), Capital Facilities and Technology (CFT) and Innovative Programs (INN), which account for the full MHSA funding received by Alameda County[1].

I. COMMUNITY SERVICES AND SUPPORTS

a. Full Service Partnerships
b. Outreach, Engagement and System Development (OESD) Programs

II. PREVENTION AND EARLY INTERVENTION (PEI)

a. PEI Programs focused on the African American Community Update

III. INNOVATION

a. INN Programs under Procurement
b. New INN Programs under Development for Future Procurement

IV. WORKFORCE DEVELOPMENT AND TRAINING (WET)

V. CAPITAL FACILITIES AND TECHNOLOGICAL (CFTN) NEEDS

I. COMMUNITY SERVICES AND SUPPORTS

a. FULL SERVICE PARTNERSHIP PROGRAMS

Full-Service Partnership (FSP) Update

Alameda County currently has 890 on-going FSP slots distributed across 11 programs. In early FY 19/20 100 additional partner slots (50 per homeless focused FSP) became available for the target population of individuals who are homeless and struggling with severe mental illness and co-occurring physical health and/or substance use disorders. These 100 additional slots will be a pilot for three years (FY 19/20- 21/22) to determine

[1] It should be noted that MHSA ongoing budget allocations are set on an annual basis and any unused funds at the end of a fiscal year *do not* roll over into future years.

their effect on the homelessness crisis in Alameda County. Connected to these 100 slots will be housing subsidies in order to rapidly house the FSP clients. Below are the FSP programs and the partner slots:

Program	Awarded Provider / Partners served
Birth – 8 FSP	• **Seneca—20 youth**
Child & Youth FSP (8-18)	• **Fred Finch Youth Center—20 youth**
TAY FSPs	• **Fred Finch Youth Center; North County—100 Partners** • **Bay Area Community Services (BACS); South County—50 Partners**
Forensic FSPs	• **Bay Area Community Services (BACS)—100 Partners** • **Telecare—100 Partners**
Adult FSPs	• **Telecare STRIDES—100 Partners** • **Telecare CHANGES—100 Partners**
Homeless FSPs	• **Bay Area Community Services (BACS)—100 Partners, 50 (pilot) Partners** • **Abode Greater Hope—100 Partners, 50 (pilot) Partners**
Older Adult FSP	• **Bay Area Community Services (BACS)—100 Partners**

Expansion of the FSP Housing Support Program (HSP)

ACBH has successfully moved forward with an expansion of its subsidized licensed board and care beds as well an increase in the rates paid to operators. This expansion includes an augmentation to the existing rate of $625/bed per month to $1,000/bed per month for 250 beds. Additionally, it's the goal to add 50 new slots for those with more intensive care and supervision needs with rates of $2,000 or $3,000/bed per month

Through a public request for proposal (RFP) process ACBH has been able to bring on six additional licensed board and care homes for approximately 36 additional beds, with an additional seventh board and care site pending. These new sites, as well as the existing sites will be able to apply for the higher rate level based on the client's physical and mental health care needs. The ACBH Housing Division will continue working to bring on additional licensed board and care operators until the goal of 300 beds is secured.

For more information see FSP #10.

b. Outreach, Education and System Development (OESD) Programs in Development or Start Up

MHSA Braided funding for Expansion of School-Based Behavioral Health in the Oakland Unified School District (OUSD)

In FY 19/20 the ACBH Child, Youth and Young Adult System of Care re-bid its Counseling-Enriched Special Day Class (CESDC) programs and two of its School Based Behavioral Health (SBBH) programs in partnership OUSD. The children and youth who qualify for these mental health services do so under the category of Severely Emotionally Disturbed (SED) as identified through the assessment process and an Individual Education Plan (IEP). CESDC programs are funded through Educationally Related Mental Health Services (ERMHS) and the two SBBH programs are funded through Early Periodic Screening Diagnosis and Treatment (EPSDT) funds.

As part of these procurement processes it was identified that there were additional non Medi-Cal billable services and supports that were needed to assist the children and their families receiving mental health services in order for them to be successful in school and at home. The MHSA funds will be braided with ERMHS and EPSDT funds as a pilot for three years (FY 19/20- 21/22). During this time period the addition of these funds will be monitored to determine their effect and potential continued use. Examples of key areas for which the flexible funds could be used include:

- Supporting case carrying clinicians with initial intake and outreach to students and families prior to the Medi-Cal Episode Openings (which is currently not billable);
- Providing additional support during summer months when students may or may not be enrolled in school based programs;
- As needed, provide trainings, coaching and consultation to school site faculty and staff on strategies for de-escalation, trauma informed practices, and positive school climate work;
- Support students as needed with Daily Living Skills activities as they relate to their treatment goals (i.e. coaching on organizing their school work, navigating bus schedules, job applications and/or volunteer activities), and
- Family coaching and support with accessing various systems and community resources (i.e. assisting families in completing Medi-Cal registration and/or renewal documents, assisting in identifying after school activities for students on SBBH Caseloads)

The following table highlights the five agencies that were awarded CESDC and SBBH programs and the schools where services will take place:

Agency	School Site
Seneca	Bridges Academy (Elementary)
	Think College Now (Elementary)
	Place @ Prescott (Elementary)
	Sequoia (Elementary)
East Bay Agency for Children (EBAC)	Castlemont (Middle and High School)
	Roosevelt (Middle)
Lincoln	McClymonds (High)
	Howard (Elementary)
	MLK (Middle)
	Skyline (High)
	Lafayette (Elementary)
Fred Finch	Westlake (Middle and High school)
	Montera (Middle)
	Oakland High
	Skyline (High)
Seneca	ASCEND Charter School
STARS	East Oakland Pride Elementary School

This program will be listed in future MHSA Plans as OESD #34

Opening of the New Crisis Residential/Crisis Stabilization Program

On September 17, 2019 Amber House, the new voluntary crisis stabilization unit (CSU) and voluntary crisis residential treatment (CRT) program was opened.

Amber House CSU is a 12-bed voluntary-only CSU whose purpose will be to assess individuals who are having a mental health crisis and are in need of assessment, stabilization, and brief treatment. The service is available to individuals for up to 24-hours.

Amber House CRT has up to 14-beds for individuals in crisis who do not meet medical necessity criteria for hospitalization and would benefit from treatment and supportive programming. Amber House crisis services are available to only clients who are 18 and over and residents of Alameda County who possess and/or eligible for Medi-Cal.

This program will be listed in future MHSA Plans as OESD # 11.

Opening of the new Berkeley Wellness Center

ACBH and the City of Berkeley have partnered to jointly develop and open a Wellness Center for the City of Berkeley in order to serve north county residents who have a mental health diagnosis or have experienced mental health challenges who will benefit from a cohesive set of wellness and recovery services. The Berkeley Wellness Center is

run by Bonita House and opened on November 4th, 2019.

This program will be listed in future MHSA Plans as OESD # 18

II. PREVENTION AND EARLY INTERVENTION (PEI)

Faith and Spirituality-Based Mental Illness Stigma Reduction RFP targeting Africans and African Americans

On July 11, 2019 ACBH released a Request for Proposal (RFP) #19-10 Faith and Spirituality-Based Mental Illness Stigma Reduction Services for Africans and African Americans. This is the second of two programs that'll be implemented for the purpose and focus of delivering stigma and discrimination reduction services to and from the African American faith-based community. The first program was awarded to the agency Peers Envisioning and Engaging in Recovery Services (PEERS).

The awarded entity for this second program is Tri Cities Community Development Center. They will develop and implement a training curriculum and stigma reduction campaigns for faith-based groups to support their communities in addressing the mental health needs of African and African American consumers and their family members. Faith-based groups may include churches, congregations, and/or religious or spiritual organizations. Workshops/trainings as well as ongoing mental health consultation for faith leaders will also be provided through this program. It's estimated that this contract will start in early 2020.

This program will be listed in future MHSA Plans under PEI # 20E.

III. INNOVATION (INN)

a. Approved INN Programs being Implemented in FY 19/20

The Mental Health Services Oversight and Accountability Commission has approved two new INN programs for Alameda. The Mental Health Technology Applications INN project was approved on April 25th (FY 18/19) and the Alameda County Supportive Housing Community Land Alliance was approved on August 22nd (FY 19/20). A full description and proposal of both of these programs was listed in the MHSA FY 18/19 Plan Update. A brief summary of each of these projects is included in the Innovation section of this Plan Update.

b. New INN Programs under Development

ACBH is currently exploring a small INN proposal for the purpose of utilizing INN funds as part of the upcoming Community Planning Process (CPP) for the next Three Year MHSA Plan (FY 20/21-22/23). The County continues to be fully invested in having a dynamic CPP, which will include the community's input around new INN ideas.

Alameda County is requesting Commission approval to earmark use of Innovation funds for a fixed annual allocation for community planning activities involving stakeholders, most directly,

individuals in the unserved and underserved communities of Alameda County. This annual allocation will be specific in its support of design, development and implementation of innovative ideas brought forth through the community planning process. Presently, under MHSA regulations, counties may use up to 5% of their total MHSA allocation to fund community program planning, and designate positions for oversight and support. However, in order to use INN funds for community planning this must also be approved by the Mental Health Services Oversight and Accountability Commission once a county Board of Supervisors approves the MHSA Three Year Plan or Plan Update.

The full proposal for this project is listed in Appendix A.

IV. WORKFORCE DEVELOPMENT AND TRAINING (WET)

Although WET and CFTN have completed their ten-year block grant period from the Mental Health Services Act at the end of FY 2017/18 ACBH is committed to continue WET activities.

New WET Programming

The ACBH WET team will be partnering with Ohlone Community College to develop a Mental Health Advocacy Training Pilot Program that will expose students to a wide range of mental health topics and career options. This program will help to advance the collective work of ACBH and the State of California's Office of Statewide Health Planning and Development's ongoing efforts to address the shortage of mental health practitioners in our communities. The pilot program will take place over the course of eight months during the 2019-20 academic year.

The Mental Health Student Advocacy Pilot Program will recruit a cohort of up to eight students from two key programs with populations that experience disproportionate levels of mental health issues and challenges in accessing care, these programs are: 1) Puente Program Learning Community and 2) the Genders and Sexualities Alliance student club and 3) Umoja Scholars Program.

The pilot program will be a blended model that will expose students to mental health related careers and help position Ohlone College to become a key workforce development player in advancing Alameda County's efforts to expand postsecondary education and training to meet mental health occupation shortage needs. Students will also carry out service-learning projects to promote student mental health, connect students to campus-based and community-based mental health services, and reduce stigma associated with help-seeking behavior.

V. CAPITAL FACILITIES AND TECHNOLOGICAL NEEDS (CFTN)

New Capital Facilities & Technological Needs (CFTN) Projects

Housing and homelessness for individuals with severe mental illness as well as access to crisis services continue to be a top priority for ACBH. The Department also continues their focus on significant technological needs in order to maintain efficiency and effectiveness, especially in

regards to the identification and implementation of a new electronic health records (EHR) system.

During FY 19/20 a number of CFTN projects that were listed in the FY 18/19 Plan were started in early FY 19/20. These projects include the following:

Capital Project Investments to Expand Respite Beds for Individuals with Serious Mental Illness and Physical Health Care Needs:

ACBH currently has contracts for 78 emergency housing beds for individuals with a serious mental illness countywide. ACBH proposed in its FY 18/19 Plan Update to utilize one-time CFTN funding to increase temporary housing capacity for individuals with serious mental illness and acute health care needs through the renovation of various properties in Alameda County. The goal is to add at least 30 beds in the next 12 to 18 months. The first of these projects has started in FY 19/20 and is called the Adeline Street Recuperative Care program, which will be run by LifeLong Medical Care, which is a Federally Qualified Health Center and a partner to ACBH on multiple programs.

The Adeline Street Recuperative Care program is a medical respite program that will provide a safe place to recuperate, medical services, and behavioral health support. The behavioral health and linkage services will be coordinated in the same manner as with the current emergency housing beds. The facility is open 7 days a week, accepting patients from 8am until 3pm Monday through Friday. The program maintains 27 beds (3 first floor ADA accessible beds and 24 beds on a second floor with no elevator). Staffing will include RNs, LVNs, case managers and medical providers. The average length of stay is 45 days and is not to exceed 90 days.

MHSA Technology Project

ACBH has utilized CFTN funds to contract with an agency, XPIO, to develop a scope of services and requirements for the procurement process for a new EHR system. This system will include: billing, managed care, e-prescribing functions, data interoperability and functions as needed to support clinical and fiscal operations of ACBH.

It's the goal to have an RFP released by January 2020 and a contract in place by the end of FY 19/20 for work to begin in FY 20/21. More information will be shared with the community when available.

Alameda County Demographic Information

Demographics

Alameda County is the seventh most populous county in California, with the City of Dublin being one of the 15 fastest growing cities in the United States. Compared to neighboring Bay Area counties, Alameda, experienced the highest numeric increase in population from 2017 to 2018 with over 8,500 people and the second highest number of people migrating internationally (10,717). Since the 2010 Census, the population has increased 10.2%, the highest of any Bay Area County (**Table 1**).

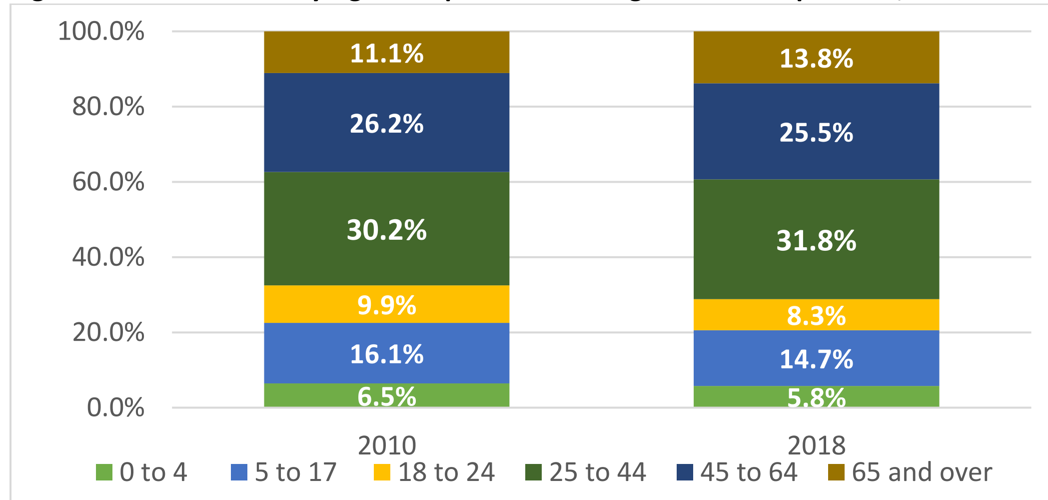
Table 1: Population Characteristics of Alameda and Neighboring Bay Ares Counties

Description	Alameda	Contra Costa	Marin	San Francisco	Santa Clara
Census, April 1, 2010	**1,510,271**	1,049,025	252,409	805,235	1,781,642
Estimates base, April 1, 2010, (V2018)	**1,510,258**	1,049,204	252,423	805,184	1,781,672
Estimates, July 1, 2018, (V2018)	**1,666,753**	1,150,215	259,666	883,305	1,937,570
Change April 1, 2010 (estimates base) to July 1, 2018, (V2018)	**10.40%**	9.60%	2.90%	9.70%	8.80%
Total change estimates, July 1, 2017 to July 1, 2018	**8,622**	5,352	-59	4,139	4,187
International migration estimates, July 1, 2017 to July 1, 2018	**10,717**	3,841	545	6,387	17,893

Source: 2018 Census QuickFacts, Retrieved September 2019

Even though Alameda County is growing in size, the number of children is decreasing and overall the county is aging; according to the Census Bureau the median age has increased from 36.6 in 2010 to 37.7 years in 2018. Between 2010 and 2018 Alameda County was home to a smaller proportion of children 0 to 4 years old (6.5% to 5.8%), youth 5 to 17 (16.1% to 14.7%), young adults 18 to 24 (9.9% to 8.3%), and adults 45 to 64 (26.2% to 25.5%). The two age groups that increased between 2010 and 2018 were adults 25 to 44 (30.2% to 31.8%) and adults 65 and older (11.1% to 13.8%) (**Figure 1**). Women are 50.8% of the county population and is home to 53,532 Veterans (2013-2017), which is the second-highest number among Bay Area counties with Santa Clara having the most and San Francisco having the least.

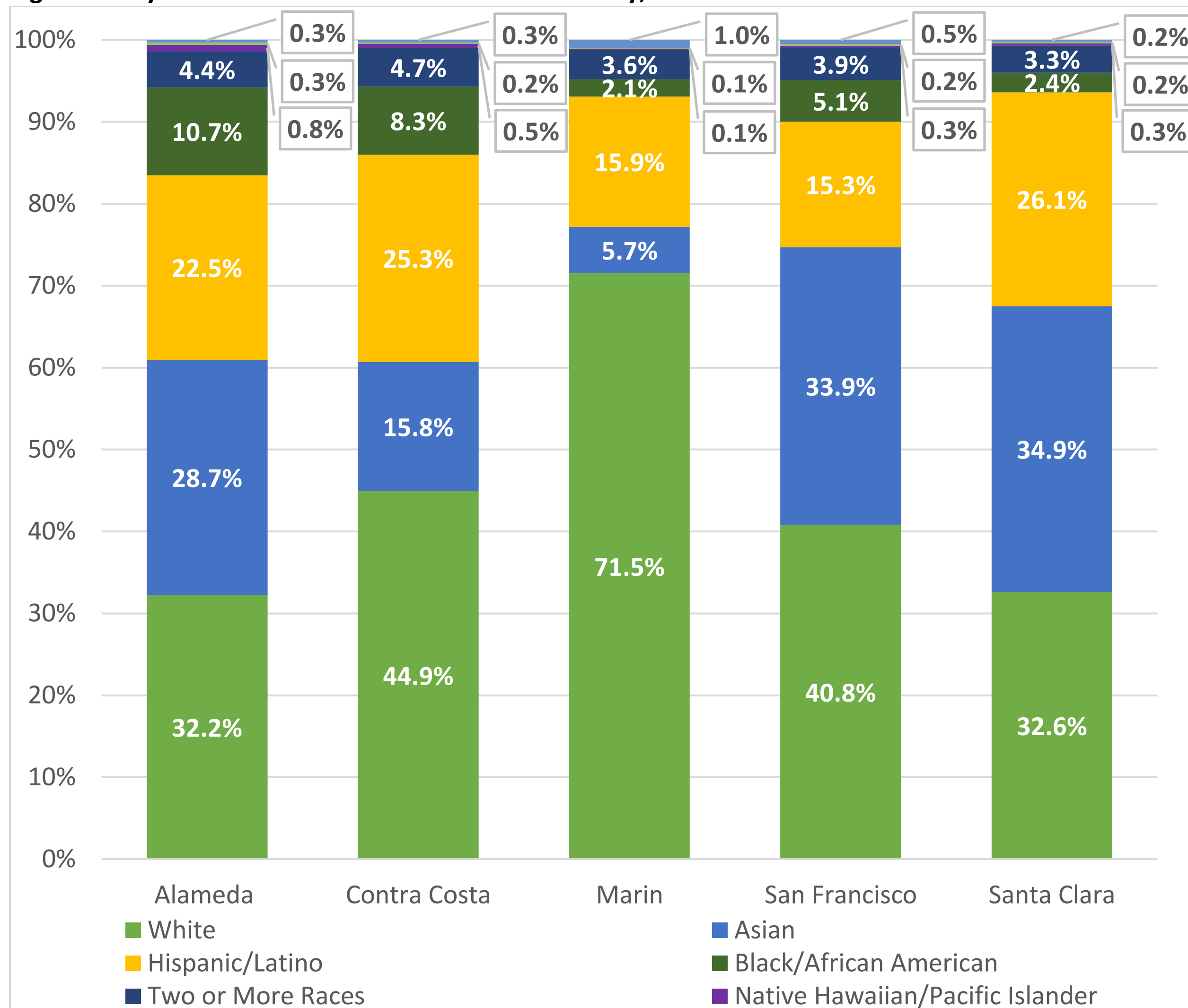
Figure 1: Alameda County Age Group as a Percentage of Total Population, 2010 v. 2018



Source: Annual Estimates of the Resident Population for Selected Age Groups: April 1, 2010 to July 1, 2018. Source: U.S. Census Bureau, Population Division. Release Date: June 2019.

Alameda County ranks as one of the most diverse counties, consisting of 32.2% White, 28.7% Asian, 22.5% Hispanic/Latino, 10.7% Black/African American, 4.4% Two or more races , 0.8% Native Hawaiian/ Pacific Islander, and 0.3% each of American Indian/Alaska Native and Some Other Race (**Figure 2**). The percentages of Asian, Native Hawaiian/Pacific Islander, and Black/African American populations of Alameda County are each approximately double the State of California's same populations.

Figure 2: Bay Area Counties Percent Race and Ethnicity, 2013-2017 Five-Year Estimates

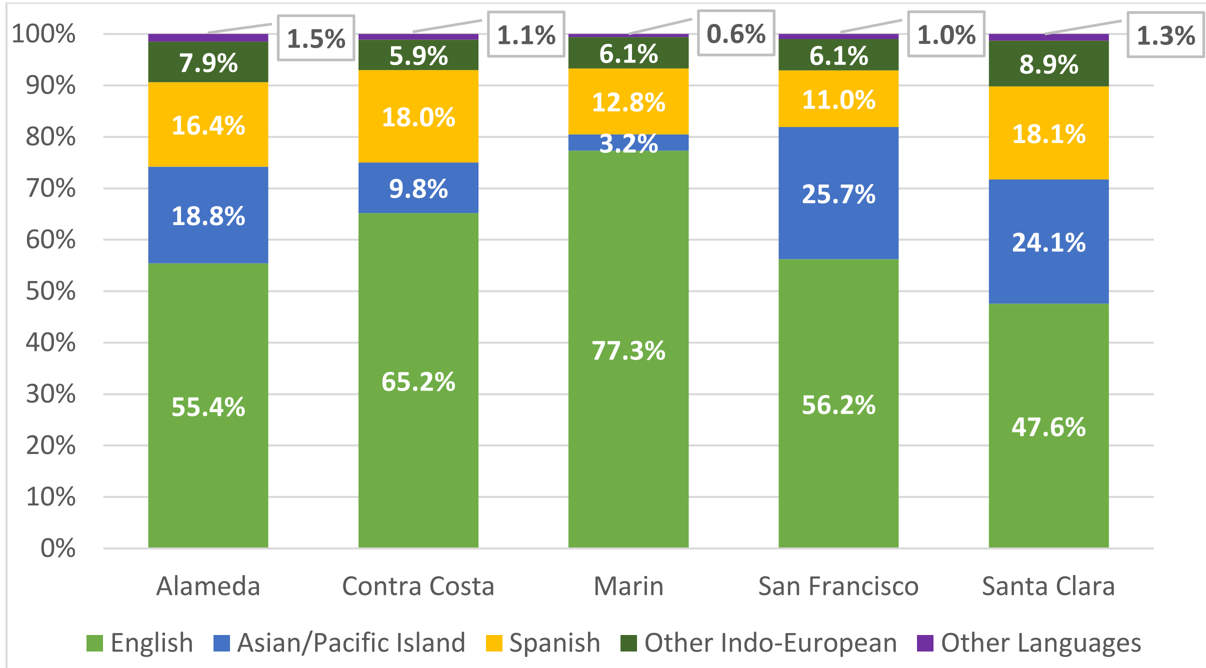


Source: U.S. Census Bureau, 2013-2017 American Community Survey 5-Year Estimates

At home, Alameda County residents speak a variety of languages. Among the neighboring Bay Area counties, Alameda has the second highest percentage of residents who speak non-English languages at home. While over half of residents speak English at home (55.4%), 18.8% of residents speak Asian/Pacific Island languages, 16.4% speak Spanish, 7.9% speak Other Indo-European languages, and 1.5% speak Other Languages (**Figure 3**). Due to this diversity of languages, Alameda County has eight threshold languages: English, Spanish, Cantonese, Chinese, Vietnamese, Farsi, Arabic, and Tagalog. Threshold languages are those where at least 3,000 residents or five percent of the Medi-Cal beneficiary population, whichever is lower, identify that language as their primary one. Mental health providers must comply with cultural competence and linguistic requirements set out by the state for

these languages, including oral interpreter services and general program literature used to assist beneficiaries.

Figure 3: Bay Area Counties Languages Spoken at Home



Source: 2018 Population Estimates Census, Release date December 2018

Burden of Poverty

Alameda County Behavioral Health (ACBH) clients face a variety of challenges around income, housing, and food security. Compared to other Bay Area counties Alameda County residents have the lowest median household and per capita income (**Table 2**). While the median rent is the lowest among the Bay Area counties, Alameda County has the second highest rental rate, meaning a higher percentage of residents do not own a home when compared to Contra Costa, Marin, and Santa Clara counties. Additionally, almost 50% of those that rent spend 30% or more of their income on their rent, this means that the rent they pay is burdensome. Alameda County also has the highest percentage of people in poverty for all ages and for children. The Supplemental Nutrition Assistance Program (SNAP) is a federal program for low-income individuals that provides help with purchasing food and beverages. Even though only 6.3% of Alameda County residents receive SNAP, this is the second highest percentage compared to neighboring counties, and ACBH clients report that they do not know where they would go if they needed help with food[1].

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[1] Mental Health Services Act FY 18-19 Plan Update

Table 2: Poverty Indicators for Bay Area Counties

Indicator	Alameda	Contra Costa	Marin	San Francisco	Santa Clara
Median household income±, 2013-2017	**$85,743**	$88,456	$104,703	$96,265	$106,761
Per capita income, past 12 months±, 2013-2017	**$41,363**	$42,898	$66,748	$59,508	$48,689
Median gross rent, 2013-2017	**$1,547.00**	$1,600.00	$1,863.00	$1,709.00	$1,955.00
Rental Rate, 2013-2017	**47.0%**	34.5%	35.8%	62.7%	40.1%
Households whose rent is 30% or more of their income	**49.7%**	53.7%	55.0%	37.1%	47.3%
Poverty percent, all ages	**10.7%**	8.7%	7.8%	10.2%	9.3%
Poverty percent, under 18	**12.4%**	10.3%	8.5%	11.3%	10.4%
Households with SNAP, percent	**6.3%**	6.8%	3.9%	4.7%	4.6%

±In 2017 dollars
Sources: Census QuickFacts 2019, 2017 American Community Survey, and Small Area Income and Poverty Estimates (SAIPE) Program, Release date: November 2017

Every two years, the Alameda County Continuum of Care (ACCC), conducts comprehensive counts of the homeless population in Alameda County to measure the prevalence of homelessness as part of the required Point-in-Time Count. The 2019 count recorded 8,022 people experiencing homelessness, which is a 43% increase from the last count in 2017. Seventy-nine percent were unsheltered—living in tents, parks, vehicles, vacant buildings, underpasses, etc. According to the EveryOne Counts 2019 report, Alameda, San Francisco, and Santa Clara reported increases in overall homelessness in 2019. See Appendix D for Alameda County 2019 EveryOne Counts 2 page summary. The full report can be found here .

During the count, ACCC conducted a survey on a randomized sample of 1,681 unsheltered and sheltered homeless persons. The top three reported causes of homelessness were: lost their job (13%), mental health issues (12%), and substance use issues (10%). Participants reported that the following might have prevented homelessness (multiple responses allowed):

- Rent assistance - 33%
- Benefits/income - 30%
- Employment assistance - 23%
- Mental health services - 21%
- Alcohol/drug counseling - 17%

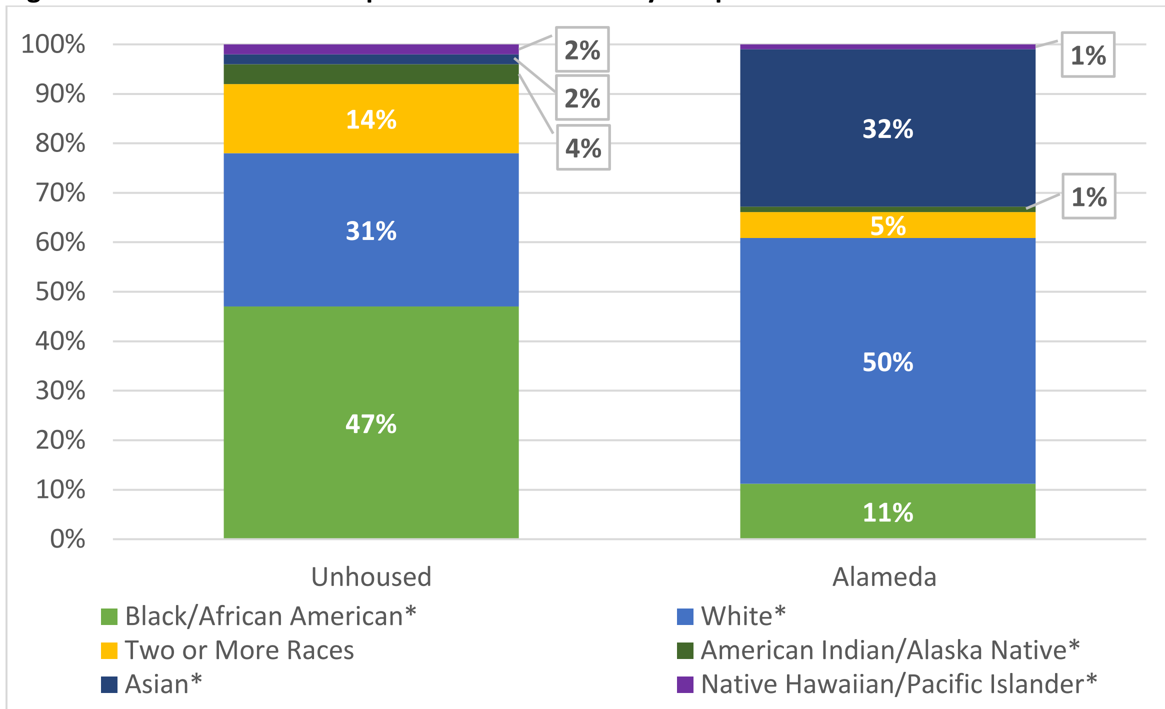
Survey respondents reported the following health conditions: psychiatric/emotional conditions (39%), alcohol and drug use (30%), post-traumatic stress disorder (30%), and traumatic brain injury (13%). Only three percent of respondents were not interested in independent, affordable rental housing or housing with supportive services. The lack of affordable housing has impacted Alameda County residents, the workforce, and consumers and family members in MHSA programs. A number of Full Service Partnership (FSP) providers have reported that the lack of affordable housing is a major challenge for many FSP clients[2] and this is reflected in the increase in homelessness.

Multiple populations were overrepresented in the homeless populations, compared to the overall

[2] Mental Health Services Act FY 18-19 Plan Update

Alameda County population, e.g. veterans (9% versus 5%) and adults with serious mental illness when compared to rates in the United States population (32% versus 5%). Compared to the general Alameda County population the unhoused population has an overrepresentation of Black or African Americans, Two or More Races, American Indian or Alaska Native, Native Hawaiian or other Pacific Islander (**Figure 4**), and Hispanic or Latino (22% versus 17%). While Whites and Asians are seen in the homeless population at lower rates than the general population. Those with a history of domestic violence or abuse were 26% of the homeless population.

Figure 4: Unhoused Race Compare to Alameda County's Population



*Includes persons reporting only one race
Source: 2019 Census Quickfacts and Alameda County: Homeless Count and Survey Comprehensive Report 2019

Alameda County Health Information

Physical Health

Alameda County has the second lowest life expectancy, at 82.7 years, of any of the neighboring counties (range 82.2 - 85.1). Alameda and San Francisco counties have much higher rates of violent crime than the other neighboring counties. Those without health insurance under the age of 65 (range 5.1% - 5.9%) have similar rates across all neighboring Bay Area counties. The percentage of those under 65 that are disabled, defined as limited or restricted to fully participate in activities at school, home, work, or in their community, is 6.1% (**Table 3**).

Table 3: Health Indicators for Bay Area Counties

Indicator	Alameda	Contra Costa	Marin	San Francisco	Santa Clara
Life expectancy, years	**82.7**	82.2	85.1	83.5	84.4
Violent crime rate (per 100,000 population)	**629**	336	178	760	264
Persons without health insurance, under age 65 years	**5.8%**	5.9%	5.4%	5.0%	5.1%
With a disability, under age 65 years, 2013-2017	**6.1%**	7.5%	5.1%	6.1%	4.4%

Sources: County Health Rankings and QuickFacts 2019

In contrast to life expectancy, Alameda County has the second lowest age-adjusted[2] death rates due to drugs (9.9) or suicide (8.6) per 100,000 when compared to its neighboring counties (**Table 4**). These are lower than the Healthy People 2020 Objective of 11.3 and 10.2 per 100,000, respectively. However, these low rates do not reflect the differences in these rates among different populations in Alameda County. For example, the Centers for Disease Control and Prevention reports that nationally the highest rates of suicide across the life span occur among American Indian/Alaska Natives and Whites. Veterans and sexual minority youth also have higher rates of suicide. Additionally, suicide is the second leading cause of death for those between the ages of 10 to 24 and increased from 6.8 in 2007 to 10.6 per 100,000 in 2017.

Table 4: Selected Causes of Death, 2015-2017

County	Drugs		Suicide	
	Deaths (Average)	Age-Adjusted Death Rate+	Deaths (Average)	Age-Adjusted Death Rate+
Alameda	**175.0**	**9.9**	**149.3**	**8.6**
Contra Costa	130.7	11.2	120.3	10.3
Marin	32.7	12.4	40.3	12.7
San Francisco	194.7	19.1	105	10.5
Santa Clara	162	7.7	148.7	7.4
Healthy People 2020 Objective	-	11.3	-	10.2

+per 100,000 people

Source: California Department of Public Health, California Comprehensive Master Death Files, [2015-2017] Compiled, August 2018.

Mental Health

The California Health Interview Survey (CHIS) is conducted continuously through internet and telephone surveys to give a detailed picture of health and the healthcare needs of Californians, this includes a set of questions about mental health. Aside from Marin, all of the neighboring counties have a similar percentage of people that have “likely had psychological distress during the last year” (range 4.9% - 8.1%), with 7.8% of Alameda County residents reporting distress (**Table 5**). Alameda had the second highest percentage of people that reported a moderate or severe “social life impairment” during the past year (14.1%), as well as 9.1% who reported that they had “ever seriously thought about committing suicide.” In Alameda County, 18.4% of respondents reported that they “needed

[2] Rates are age-adjusted to correct for the influence of age on health outcomes, allowing counties with different age profiles to be compared.

help for emotional/mental health problems or use of alcohol/drugs" and of those, 59.4% of them reported receiving treatment, which is the second highest percent. The ratio of mental health providers to residents is 1:170 in Alameda County, which makes it in the middle among neighboring counties.

Table 5: Mental Health Indicators for Adults in Bay Area Counties

Indicator	Alameda	Contra Costa	Marin	San Francisco	Santa Clara
Likely has had serious psychological distress in the past year	**7.8%**	7.9%	4.9%	8.1%	6.4%
Moderate or severe social life impairment in the past year	**14.1%**	13.8%	13.5%	16.4%	11.3%
Ever seriously thought about committing suicide	**9.1%**	8.6%	7.6%	12.4%	7.0%
Needed help for emotional/mental health or alcohol/drugs	**18.4%**	15.8%	22.8%	23.9%	14.1%
Received treatment for mental/emotional and/or alcohol/drug issue	**59.4%**	56.2%	73.4%	57.5%	59.4%
Residents per Mental health provider	**170:1**	310:1	140:1	120:1	310:1

Source: 2014, 2015, 2016, 2017 California Health Interview Survey and County Health Rankings

While Alameda County and neighboring counties are similar on mental health indicators, overall there are inequities in these same measures across racial and ethnic groups in the county (**Table 6**). African Americans have higher rates of "serious psychological distress in the past year" (8.8%). Whites reported the highest rate of "moderate or severe social life impairment during the past year" (15.8%) and 13.5% reported that they had "ever thought about committing suicide." Additionally, those that are Two or More Races had a much higher percentage reporting that they "needed help for emotional/mental health or alcohol/drugs" (32.3%). Among those that needed help for emotional/mental health problems Hispanic/Latinos and Asians were the least likely to receive help. These rates do not reflect the role that stigma might play in survey participant's responses that may result in underreporting among certain racial and ethnic groups.

Table 6: Mental Health Indicators for Alameda County Adults by Race/Ethnicity

Indicator	Hispanic/ Latino	White	Black/ African American	Asian	Two or More Races
Likely has had serious psychological distress in the past year	7.0%	7.6%	8.8%	5.4%	-
Moderate or severe social life impairment in the past year	10.9%	15.8%	14.6%	*	*
Ever seriously thought about committing suicide	6.2%	13.5%	8.7%	*	*
Needed help for emotional/mental health or alcohol/drugs	16.7%	22.0%	18.8%	14.5%	32.3%
Received treatment for mental/emotional and/or alcohol/drug issues	50.3%	60.0%	67.1%	50.2%	65.2%

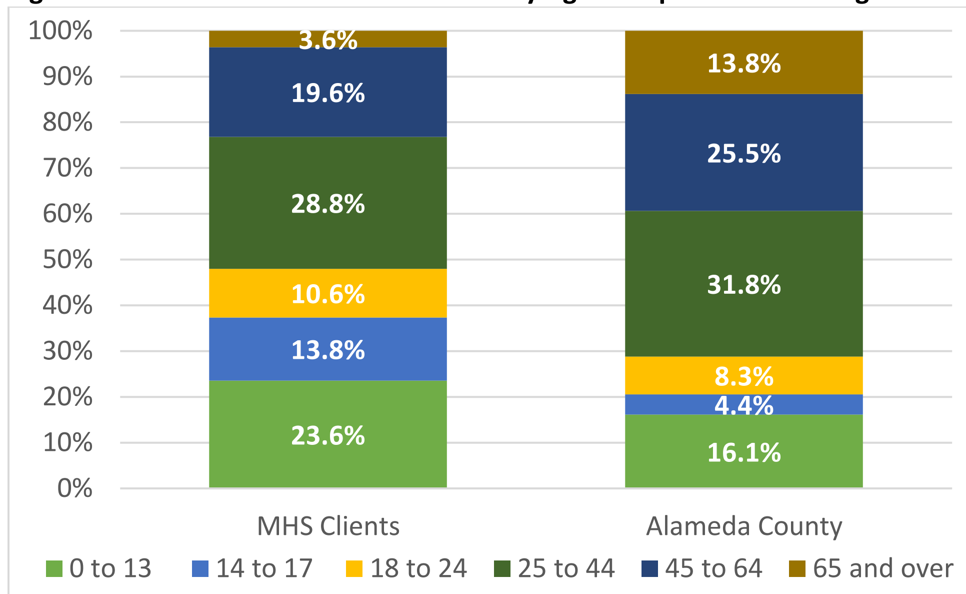
* = suppressed because statistically unstable; -= suppressed due to sample size
Note: American Indian or Alaska Native and Native Hawaiian or Pacific Islander suppressed due to statistically unstable or sample size.
Source: 2011 - 2017 California Health Interview Surveys

Alameda County Behavioral Health Services Utilization

During FY2018/19, ACBH provided behavioral health services to total of 28,636 clients and consumers. Adults 25 and over make up the majority of the consumer population (52.0%). Children and Youth 0 to 13 are 23.6%, teenagers 14 to 17 are 13.8%, and Young Adults 18 to 24 are 10.6% of the clients. ACBH serves more men (54.0%) than women (46.0%). Nationally women have higher rates of any mental

illness (22.3% versus 15.1%), severe mental illness (5.7% versus 3.3%), and treatment for mental illness (47.6 versus 34.8)[3].

Figure 5: ACBH Clients and Alameda County Age Groups as a Percentage of the Total Population



Total MHS Clients is 28,636, current breakdown excludes 47 clients of unknown age.

Table 8 shows the mental health services penetration rate by race and ethnicity. The penetration rate is the percentage of eligible Medi-Cal insured individuals who are utilizing mental health services. Despite having the second highest number of beneficiaries, Asians have the lowest penetration rate at 1.1%. Alaska Native/American Indian represent the highest penetration rate (8.3%), with the other rates by race/ethnic groups penetration rates as follows 8.0% of Black/African Americans, 7.5% of Pacific Islanders, 6.4% of Whites, 4.9% of Hispanic/Latinos, and 4.5% of Other/Unknown of Alameda County Medi-Cal beneficiaries.

Table 8: Fiscal Year 18/19 ACBH Medi-Cal Penetration Rate by Race & Ethnicity

Race/Ethnic Group	Beneficiaries	Served with Medi-Cal	Penetration Rate	Served in Outpatient	Outpatient Penetration Rate	Served without Medi-Cal	Total Served
Pacific Islander	724	54	**7.5%**	40	5.5%	46	100
Alaska Native/American Indian	1,295	108	**8.3%**	81	6.3%	29	137
White	56,259	3,625	**6.4%**	2,421	4.3%	1,554	5,179
Black/African American	86,084	6,871	**8.0%**	4,834	5.6%	1,641	8,512
Other/Unknown	97,452	4,422	**4.5%**	2,965	3.0%	1,721	6,143
Asian	106,288	1,705	**1.6%**	1,204	1.1%	654	2,359
Hispanic or Latino	122,039	5,961	**4.9%**	5,195	4.3%	197	6,158
Total	**470,141**	**22,746**	**-**	**16,740**	-	**5,842**	**28,588**

Exploring the Medi-Cal penetration rate by language shows that the lowest penetration rates are

[3] Substance Abuse and Mental Health Services Administration's National Survey of Drug Use and Health, 2017

among Chinese, Tagalog, Vietnamese, and Arabic speaking individuals. English speakers are the largest group of beneficiaries and have the highest penetration rate. Overall, 4.8% of beneficiaries are accessing mental health services in Alameda County. Results from the Substance Abuse and Mental Health Services Administration's National Survey of Drug Use and Health (2017), showed that rates of serious mental illness is 4.5% of adults and 8.2% of adults who are provided health insurance through Medicaid/CHIP[4].

Table 9: Fiscal Year 18/19 ACBH Services Medi-Cal Penetration Rate by Language

Language Group	Beneficiaries	Served with Medi-Cal	Penetration Rate	Served in Outpatient	Outpatient Penetration Rate	Served without Medi-Cal	Total Served
Farsi	2,793	141	**5.0%**	121	4.3%	8	149
Arabic	3,239	43	**1.3%**	38	1.2%	4	47
Tagalog	3,846	44	**1.1%**	31	0.8%	0	44
Vietnamese	11,680	142	**1.2%**	117	1.0%	6	148
Other	19,166	778	**4.1%**	403	2.1%	345	1,123
Chinese	38,266	341	**0.9%**	249	0.7%	32	373
Spanish	84,818	3,559	**4.2%**	3,331	3.9%	830	4,389
English	306,333	17,698	**5.8%**	12,450	4.1%	4,617	22,315
Total	**470,141**	**22,746**	**-**	**16,740**	**-**	**5,842**	**28,588**

[4] Medi-Cal is called Medicaid nationally. CHIP is the Children's Health Insurance Program. Individuals aged 19 or younger are eligible for this plan.

A. COMMUNITY SERVICES & SUPPORTS (CSS) PROGRAM SUMMARIES

COMMUNITY SERVICES AND SUPPORTS (CSS) COMPONENT

The Mental Health Services Act (MHSA) encompasses five service components. The Community Services & Support (CSS) component is the largest with 76% of a county's MHSA allocation reserved for this component.

CSS provides funding and direct services to individuals with severe mental illness. The CSS component is comprised of two service areas: Full Service Partnerships (FSPs) and Outreach Engagement/System Development (OESD) programs. FSPs provide wrap around or "whatever it takes" services to consumers, who are called partners. OESD programs cover multiple treatment modalities and services including: outpatient treatment: crisis response: crisis stabilization and residential care; peer respite; behavioral health court; co-occurring substance use disorders; integrated behavioral health & primary care; integrated behavioral health & developmental disability services, and in-home outreach**.**

CSS programs focus on community collaboration, cultural competence, client and family driven services and systems and wellness. Housing is also included in the CSS component

Alameda County Behavioral Health (ACBH) funds 12 FSPs and 21 OESD programs. CSS programs are implemented through ACBH age based Systems of Care:

1) Children/ Youth (0-15 yrs.) and Transitional Age Youth (16 – 24 yrs.) and
2) Adults (18 – 59 yrs.) and Older Adults (60+ yrs.)

CSS programs address one of the following priorities developed in the community planning process:

- Reduce homelessness
- Reduce involvement with justice and child welfare systems
- Reduce hospitalization and frequent emergency medical care
- Promote a client- and family-driven system
- Reduce ethnic and regional service disparities
- Develop necessary infrastructure for the systems of care

CSS Plan Requirements

CSS funded programs must following the following guidelines:

- All ages must be served;
- At least 51% of the funds must support Full Service Partnerships, and
- Address disparities in access to services for underserved populations and regions of the County.

A. COMMUNITY SERVICES & SUPPORTS (CSS) PROGRAM SUMMARIES

FULL SERVICE PARTNERSHIP (FSP) PROGRAMS

FY 2018/19 FSP Impact Objectives

FSP providers worked with ACBH to develop impact benchmarks in a number of areas. The first three metrics below are looking at FSP partners who've received FSP services for at least 12 months. The goal is to see what percent of partners can achieve a 50% reduction in: 1) psychiatric hospitalization admissions, 2) psychiatric hospital days and 3) psychiatric emergency visits 12 months prior to FSP admission and 12 months post admission.

Metrics 4 and 5 are new metrics that are being piloted and are tied to incentive payments as ACBH is moving toward a pay for performance fiscal model.

1. Reductions in Psychiatric Hospital Admissions: Client use of psychiatric hospitalization services, measured in client admissions, shall decrease by 50% in the most recent 12 months, compared to the 12 months prior to enrollment.

2. Reductions in Psychiatric Hospital Days: Client use, measured is days, of a psychiatric hospitalization, shall decrease by 50% in the most recent 12 months, compared to the 12 months prior to enrollment.

3. Reductions in Psychiatric Emergency visits: Client use of psychiatric emergency services, measured in client admissions, shall decrease by 50% in the most recent 12 months, compared to the 12 months prior to enrollment.

4. FSP Acute Follow up within 2 Days: The percent of FSP partners who were seen (face-to-face) by their FSP staff within two days of: discharge from a hospital for a mental health diagnosis, discharge from an institution of mental disease, receiving crisis stabilization (CSU), discharge from psychiatric health facility, and/or discharge from the County Justice System.

5. FSP Average of 4+ Visits per Month: The percent of FSP partners who have been open to a provider for at least 30 days who have had 4 or more face to face visits with FSP staff.

Please see the following pages for aggregated FY 18/19 FSP outcomes. Individual FSP outcomes are listed under each FSP program description.

Additional metrics are also currently being developed and will be shared in the next MHSA Three Year Plan.

FY 18/19 FSP Demographic and Outcome Data

During FY 18/19 1,065 individuals were served in one of ACBH's FSP programs. Below are demographic information on these partners.

ETHNICITY

Fiscal Year	Ethnic Group	Clients	% of Clients
FY 2018-2019	Alaska Native or American Indian	3	0%
	Asian	43	4%
	Black or African American	388	36%
	Hispanic or Latino	90	8%
	Other/Unknown	321	30%
	White	220	21%
		1,065	100%

GENDER

Fiscal Year	Sex	Clients	% of Clients
FY 2018-2019	Female	385	36%
	Male	680	64%
		1,065	100%

PRIMARY LANGUAGE

Fiscal Year	Language Group	Clients	% of Clients
FY 2018-2019	Arabic	2	0%
	Chinese	4	0%
	English	954	90%
	Farsi	1	0%
	Other	78	7%
	Spanish	23	2%
	Vietnamese	3	0%
		1,065	100%

AGE

Age	Clients	% of Clients
0-8 yrs	20	2%
9-18 yrs	53	5%
19-24 yrs	130	12%
25-59 yrs	654	61%
59+ yrs	208	20%
	1,065	**100%**

COUNTY REGION CLIENTS RESIDE IN

Fiscal Year	Region	Clients	% of Clients
FY 2018-2019	1. North	552	52%
	2. Central	394	37%
	3. South	44	4%
	4. East	28	3%
	5. Out of County	47	4%
		1,065	100%

OUTCOME METRICS

1. Reductions in Psychiatric Hospital Admissions: Of the clients served in FY 18/19 who've been in an FSP for at least 12 months and have an episode open, 63% have had a 50% or more reduction in the number of hospital admissions pre FSP enrollment.

Hospital Admit Goal Met	Active Eligible Clients	% of Clients	Hospital Admits Year Prior to FSP Admit	Hospital Admits Last Year
No	72	37%	89	182
Yes	123	63%	333	28
	195		422	210

2. Reductions in Psychiatric Hospital Days: Of the clients served in FY 18/19 who've been in an FSP for at least 12 months and have an active episode open, 68% have had a 50% or more reduction the number of hospital days pre FSP enrollment.

Hospital Day Goal Met	Active Eligible Clients	% of Clients	Hospital Days Year Prior to FSP Admit	Hospital Days Last Year
No	63	32%	1,002	1,814
Yes	132	68%	4,804	379
	195		5,806	2,193

3. Reductions in Psychiatric Emergency visits: Of the clients served in FY 18/19 who've been in an FSP for at least 12 months, 53% have had a 50% or more reduction in the number of psychiatric emergency visits pre FSP enrollment.

PES Admit Goal Met	Active Eligible Clients	% of Clients	PES Admits Year Prior to FSP Admit	PES Admits Last Year
No	112	47%	426	639
Yes	126	53%	636	88
	238		1,062	727

4. FSP Acute Follow up within 2 Days: The percent of FSP partners who were seen (face-to-face) by their FSP staff within two days of: discharge from a hospital for a mental health diagnosis, discharge from an institution of mental disease, receiving crisis stabilization (CSU), discharge from psychiatric health facility, and/or discharge from the County Justice System.

Hospital/Crisis Episodes	Successful 2-Day Face-to-Face Follow-Up	Success Rate (%)
2,429	1,241	51%

5. FSP Average of 4+ Visits per Month: The percent of FSP partners who've been open to a provider for at least 30 days who've had 4 or more face to face visits with FSP staff.

Clients with Episode(s)	Clients with Average of 4+ Visits Per Month	Success Rate (%)
695	421	61%

A. COMMUNITY SERVICES & SUPPORTS (CSS) PROGRAM SUMMARIES

FY 2019-20 MHSA PLAN UPDATE
COMMUNITY SERVICES & SUPPORTS (CSS) REPORT

FULL SERVICE PARTNERSHIP (FSP) REPORT
FSP # FS3

PROVIDER NAME: Fred Finch Youth Center

PROGRAM NAME: STAY (Supportive Services for Transitional Age Youth)

Program Description: Describe program components and services offered to clients and general location of services.

The STAY Program is located in Oakland and serves participants throughout Alameda County. The majority of services are provided in the community. The program provides clinical case management, crisis intervention, individual rehab, peer mentoring, medication management, IPS employment support, housing assistance, collateral support for families, and skill building and socialization groups.

Target Population: Describe information about consumers'/ clients' age group (i.e., Children/ youth, Transitional Age Youth, Adults or Older Adults; and Partners' unique needs.

The STAY Program target group is Transition Age Youth ages 18 to 24 with serious mental health conditions.

I. FY 2018-19 Program Outcomes:

a. **Unduplicated Number of Partners Served:** 71
b. **FY 2018-19 Impact:** *Increasing Income*: During the period, 14 STAY participants secured employment with the support of the program's IPS services. 3 STAY participants were granted SSI, with STAY program support required following through with application and appeals process.
   Connection to healthcare: 12 of 17 participants completing their first twelve months in the program during the period were connected to primary health care.
   Housing: During the period, the program connected 17 participants to transitional or permanent housing, and provided intervention to support 12 participants in maintaining housing.
   Education: During the period, 10 STAY participants enrolled in educational programs with support from the STAY program.
   Social Connection: The STAY Program connected 51 of 71 to social activities during the period.
   ANSA-T Results: From the start of the year to the end of the second quarter, 64% of program participants had an improved total score for the Individual Strengths domain, and 84% of participants showed improvement in at least one item of the ANSA-T during the same period.

<u>Client Story:</u> During the fiscal year, the STAY program had particular success in supporting one of our participants who had struggled to remain stable in the community due to her mental health symptoms and functional challenges. This 21 year-old had been hospitalized three times during the previous year, followed by an 8-month stay in an MHRC facility. After the participant settled into a new board and care home in October, the program provided frequent contacts to support her in improving daily living skills and following house rules, while coordinating closely with the facility operator to address identified needs and concerns. Meanwhile, the program's IPS staff began helping the participant take steps towards her goal of getting a job with animals, accompanying her to orientation, training and volunteer shifts at a local animal shelter. The participant's mood, hygiene and activity level improved markedly with these interventions. She was successful in maintaining stable housing during he period and did not have a single hospitalization or visit to psychiatric emergency services.

II. Please describe ways that the program strives to:

a. **Reduce mental health stigma:** The primary means through which the STAY program works to reduce mental health stigma are modeling, education, and client empowerment. The program employs two peer mentors and family partners, all of whom have lived experience with mental health issues. The peer mentors provide participants with roles modeling to challenge negative, limiting ideas about what it means to have mental health challenges. The program provides psychoeducation to participants, famililes, and community partners to increase understanding and acceptance of mental health conditions. The program uses a strength's-based, client-centered model, embodying a respect for participants' preferences and perspectives, working to counter the devaluing, depersonalizing effects of stigma. The progam helps participants to connect with jobs, volunteering, school, and social and recreational opportuinties in the community, which helps to break down internal and external assumptions based on stigma.

b. **Create a welcoming environment:** The STAY program provides a welcoming environment for participants by creating comfortable waiting spaces and meeting rooms for TAY. We provide snacks and onsite supplies to meet their basic needs for things like clothing or toiletries. We respond in a friendly, helpful manner to any potential participants or family members who contact us with questions about the program or related support needs. We work to educate staff at other agency programs who share our campus about the needs of our participants, and communicate with them to address any concerns and questions that arise. This helps to increase the liklihood of positive, welcoming interactions for any participants coming to our campus. The program hosts participants on-site for support and skill building groups twice a month, and regularly solicit participant input in planning groups and activities. We are are attuned to using person-centered language and communication styles to help participants feel understood.

III. Language Capacity for this program: The STAY program has a bilingual Spanish-speaking peer mentor, and a psychiatric nurse practitioner who speaks Korean.

IV. FY 2018-19 Additional Information: <u>None</u>

V. FY 2018-19 Challenges: The program's primary challenging during the period were related to housing and staffing. The housing crisis continued in Alameda County during the fiscal period, leaving a dearth of affordable housing units. Financial pressures have driven many board and care operators out of the business, leaving fewer supported, group living options for housing in the area. This has left more participants homeless and in sometimes stressful family living situations. The housing crisis, combined with the cost of living in the Bay Area have contributed to a much more challenging hiring environment for community mental health programs. Finding master's level clinicians for the program continues to be particularly difficult.

VI. FY 2019-20 Projections of Clients to be Served: 100

VII. FY 2019-20 Program or Service Changes: The program's capacity to serve participants will continue to increase with the expected hiring of an additional clinician during the period, as part of a program expansion iniatied with a new contract in October of 2018. The program will add the services of a Registered Nurse during the period who will provide community-based support for particpants with co-occuring health condtions, medication support, and health education to participants and STAY staff.

FY 2019-20 MHSA PLAN UPDATE
COMMUNITY SERVICES & SUPPORTS (CSS) REPORT

GOALS	% of Clients who met Goals
Reduction in Hospital Days	78%
Reduction in Hospital Admits	72%
Reduction in Psychiatric Emergency Services (PES)	68%
Partners who received a follow up visit within 2-days after a mental health hospitalization or crisis.	61%
The average of four or more visits per month per client.	68%

FY 2019-20 MHSA PLAN UPDATE
COMMUNITY SERVICES & SUPPORTS (CSS) REPORT

FULL SERVICE PARTNERSHIP (FSP) REPORT
FSP #: FS4

PROVIDER NAME: Abode Services

PROGRAM NAME: Greater HOPE FSP

Program Description: Greater HOPE is Assertive Community Treatment team model serving 150 adults who are experiencing chronic homelessness as well as symptoms from a Serious Mental Illness throughout Alameda County. Service provided include: mental health services, case manager, medication management, housing placement and support, peer mentorship, vocation services utilizing the IPS model, social activities, and peer support.

Target Population: chronically homeless adults

I. **FY 2018-19 Program Outcomes:**
   a. **Unduplicated Number of Partners Served:** 90
   b. **FY 2018-19 Impact:** We served 90 unduplicated chronically homeless adults and of those 60% are stably housing in Permanent Supportive Housing or are in interim housing or shelter. Through use of client flex funds, we helped prevented several participants from become homeless i.e. paying for Bed Bug eradication, paying rent arrears, etc.

      We have increased our impact in the Tri-Valley through our relationship with CityServe (outreach provider in the area), HOPE team, and other providers in the valley.

      We have increased our collaboration with families of GH participants and our partnership with FERC.

      We hired a Registered Nurse case manager this year. Through this team member, we are better able to provide injectable psychiatric meds as well as coordinate care when participants are hospitalized for physical health concerns.

      We have increased our coordination with Behavioral Healthcare Court so that more of the people we serve are able to access those services.

II. **Please describe ways that the program strives to:**
   a. **Reduce mental health stigma:** We currently have a peer advocate as part of the team and have 2 vacant positions. This staff person is able to model mental wellness and use their sotry of recovery as a person with lived experience to help reduce mentla health sitgma.
      Treatment Plans focus on particpant's strengths, using particpante friendly langauge, focusing on partnering with participant to identify goals, and do not require that participante relive their history through retellin their story over and over again.

      Staff particpate in normalizing activities with particiapnts like meeting for coffee, having lunch, taking a walk at the lake, etc.

Participant centered langauge is used in daily huddles and huddles focus on partiicpants needs as well as medical necessity. Services are individually taylored to meet the needs of the each participant.

b. **Create a welcoming environment:** We meet particpants where they are at and go out to meet people in their living space including encampments. We partner withour HOPE Outreach team to support us with linking with homeless participants that they have existing relationships with.

   We attend appointments with participants in environments where they might feel to as welcome in order to assit them with accessing services.

   We have created a welcoming space for in a our reception area. Particiapnts are able to come and access clothes, food, water, computers, and immediate access to a staff person through the "staff of the day".

III. Language Capacity for this program: Hindi, Punjabi, Urdu, and Vietnamese plus use of the county language line

IV. FY 2018-19 Additional Information: None

V. FY 2018-19 Challenges: We have found the Quality Assurance compliance demands for Medi-cal has been difficult to keep up with and deters from service delivery.

Participants lack of accurate reporting on medical issues and medical provider and difficulty with care coordination within clinics.

Hiring and maintaining clinical staff still remain a huge challenge. Barriers include inability for our agency to meet county salaries or other offers, Medi-cal billing demands coupled with working with a population with high acuity, and shortage of social workers.

Coordinated Entry System is quite difficult for this population to access. Participants are not appearing as being high need on the By Name List due to their poor reporting of historical information. Helping participants get "housing document" ready to be able to access Permanent Supportive Housing resources can be difficult while some is not stably housed and/or experiencing a mental health crisis.

Staff are working in increasingly unsafe environments ie encampments, group homes where there has been violence, and in order to ensure that staff are safe, we will send 2 staff out to complete visits. This creates a situation where Abode is not able to bill for services provided by both staff and can be a loss in billing.

VI. FY 2019-20 Projections of Clients to be Served: 150

VII. FY 2019-20 Program or Service Changes: We will begin providing service out of Oakland office to provide better access to our participants living in North County.

FY 2019-20 MHSA PLAN UPDATE
COMMUNITY SERVICES & SUPPORTS (CSS) REPORT

GOALS	% of Clients who met Goals
Reduction in Hospital Days	90%
Reduction in Hospital Admits	81%
Reduction in Psychiatric Emergency Services (PES)	63%
Partners who received a follow up visit within 2-days after a mental health hospitalization or crisis.	46%
The average of four or more visits per month per client.	32%

FY 2019-20 MHSA PLAN UPDATE
COMMUNITY SERVICES & SUPPORTS (CSS) REPORT

FULL SERVICE PARTNERSHIP (FSP) REPORT
FSP #: FS10

PROVIDER NAME: Alameda County Behavioral Health Care Services (ACBH) Housing Services Office (HSO) and multiple subcontractors.

PROGRAM NAME: Housing Solutions for Health

Program Description: The ACBH HSO coordinates a range of housing programs and services for individuals with a serious mental illness and their families. Together these investments focus on achieving the following core goals:

1. Increase the availability of a range of affordable housing options with appropriate supportive services so that individuals with a serious mental illness and their families can "choose", "get", and "keep" their preferred type of housing arrangement;
2. Minimize the time individuals with a serious mental illness spend living in institutional settings by increasing and improving working relationships among housing and service providers, family members, and consumers;
3. Track and monitor the type, quantity, and quality of housing utilized by and available to ACBH target populations;
4. Provide centralized information and resources related to housing for ACBH consumers, family members, and providers;
5. Coordinate educational and training programs around housing and related services issues for consumers, family members, and providers;
6. Work toward the prevention and elimination of homelessness in Alameda County.

Target Population: HSO efforts focus on helping individuals with serious mental illness in Alameda County to live in the least restrictive and most integrated setting appropriate to meet their needs. HSO efforts focus primarily, but not exclusively, on helping individuals experiencing homelessness and those with prolonged stays in institutional settings.

I. Specific program categories that operate under the ACBH HSO include:

1) Long-term housing subsidy programs and housing partnership support contracts that make it possible for individuals with serious mental illness to live in permanent supportive housing and licensed board and cares;
2) Short-term housing financial assistance to help individuals with serious mental illness to obtain and maintain housing with one-time and short-term payments of security deposits and rent;
3) Supportive services linked with permanent subsidized housing to create "permanent supportive housing" options for individuals to live in community-based rental housing settings;
4) Temporary housing programs for individuals with serious mental illness experiencing homelessness to be sheltered and supported while they work to return to permanent housing;
5) Street outreach and housing navigation services focused on helping homeless individuals with serious mental illness living in public places and emergency shelters to return to permanent, safe, and supportive housing as quickly as possible;
6) Supporting an affordable housing search website and news alerts related to current housing opportunities relevant to people with serious mental illness and extremely low incomes;
7) Referrals, coordination, clinical consultation, training ,and oversight of a network of more than 450 licensed board and care and permanent support housing slots countywide;

8) Housing education and counseling sessions at BHCS-funded Wellness Centers and other community locations;
9) Staff involvement and financial support toward countywide efforts focused on addressing homelessness;
10) MHSA affordable housing project application preparation in partnership with nonprofit affordable housing developers.

II. FY 2018-19 Program Outcomes:

Unduplicated Number of Partners Served: Number of consumers served: combined MHSA-funded housing service programs reach at least 1,500 people with serious mental illness each fiscal year.

Number of activities or services utilized: more than 450 households received long-term housing financial assistance and supportive services to keep their housing, 128 households received short-term housing financial assistance, over 120 stayed in MHSA-funded temporary housing, and more than 600 received housing-related services including outreach, navigation, or permanent supportive housing services.

% Retention Rates: permanent housing programs supported by the HSO have maintained housing retention rates of around 85%, temporary housing exits to permanent housing have remained around 35%.

III. FY 2018-19 Impact: Home is one of SAMHSA's four key dimensions of recovery (health, home, purpose, and community). Stable, safe and supportive housing reduces emergency and crisis service utilization, increases access to quality outpatient services, and improves overall health outcomes.

The HSO worked collaboratively with cities, other county departments, and affordable housing developers to secure nearly $43 million from the statewide No Place Like Home (NPLH) Program for creating more supportive housing for homeless individuals with a serious mental illness. This allocation was the largest allocation in the state in Round 1 of NPLH. This funding will help create and support 140 new housing units set aside for the target population in buildings with 638 total affordable units. These new opportunities will be available in the next 2-5 years.

ACBH moved forward with an expansion of its subsidized licensed board and care beds and an increase in the rates paid to operators. The additional funding will help the program grow from a maximum of 250 clients to a maximum of 300 with funding for higher levels of support for some clients with extensive physical health care needs in additional to mental health needs. The Alameda County Independent Living Association (www.alamedacountyila.org) continued its efforts to raise the quality of room and board housing for seniors and people with disabilities in the County. The number of members that meet quality standards continues to grow.

ACBH resources helped Alameda Point Collaborative to secure and plan for the development of a recuperative care and supportive housing project in the City of Alameda. The project will have 80-90 permanent supportive housing units for seniors age 55 and older with disabilities including serious mental illness and 50 recuperative care/medical respite beds. Residents in the City of Alameda voted to support the project moving forward and the project secured some additional local

and private funding to keep the effort moving forward. More information about the project can be found at: http://caringalameda.org/

ACBH resources continue to support the implementation of countywide and coordinated matching to permanent supportive housing opportunities through a effort known as Home Stretch (http://everyonehome.org/our-work/home-stretch/). In the upcoming fiscal year, there will be over 100 new additional permanent supportive housing opportunities created through a combination of additional HUD and ACBH MHSA housing resources.

IV. FY 2019-20 Challenges: The most significant challenge facing the Housing Services Office is the rapidly rising costs of housing within the County. The number of individuals experiencing homelessness has nearly doubled between 2015 and 2019 with an estimate of over 8,000 people experiencing homelessness on any given night - http://everyonehome.org/everyone-counts/.

The costs of housing impacts many of our service providers and their staff who cannot afford to live in the community where they work. Several of our programs have underutilized budgeted funding due to challenges with hiring and retaining staff members.

Alameda County's Coordinated Entry System (CES) for addressing homelessness is relatively new and involves many different stakeholders. Increased collaboration and coordination will be needed to ensure the maximum effectiveness of CES. Much larger investments in affordable and supportive housing are needed by multiple levels of government to ensure individuals with serious mental illness have a place to call home.

FY 2019-20 MHSA PLAN UPDATE
COMMUNITY SERVICES & SUPPORTS (CSS) REPORT

FULL SERVICE PARTNERSHIP (FSP) REPORT
FSP # FS11

PROVIDER NAME: Telecare Corporation

PROGRAM NAME: Community Conservatorship (CC) Program

Program Description: Telecare CC staff will support individuals on their journey in healing and provide a full range of services, including medical and psychiatric services, case management services, advocacy and linkage, referral to safe and affordable housing, substance use interventions and counseling, assistance with entitlements, support and education with family and significant others, connection with community resources and self-help groups. Referrals come directly from psychiatric hospitals and focus on individuals who are voluntarily willing to participate in ongoing mental health treatment and short-term Conservatorship as a way to help them transition back to community settings with support of a treatment team, conservator, and court supervision.

Target Population: Adults (Age 18 +) diagnosed with severe mental illness, many of whom would otherwise require extended care in institutional settings.

*This includes individuals who are high utilizers of mental health services and who are considered to be at great risk for psychiatric hospitalization.

I. FY 2018-19 Program Outcomes:

- **a. Unduplicated Number of Partners Served:** Community Conservatorship program provides services to 19 and in total have served 25 individuals from Alameda county.
- **b. FY 2018-19 Impact:** Telecare Community Conservatorship(CC) program is an intensive community support services using an Assertive Community Treatment (ACT) for individuals with severe mental health. The CC team provides support for partners daily, such as individual rehabilitation, targeted case management services/collateral services, and medications support. We engage with our partners up to 7 days a week to ensure they have the means and support to be successful with transitioning back in a community setting. The CC treatment also communicates daily with community supports, board and care staff, and conservators.

Client Story: BF was referred to us while she was in Villa Fairmont. She has a long history with John George and her symptoms are exacerbated by her substance use and non-adherence to treatment in the community. Her mental health symptoms impaired her ability to provide basic needs, shelter, food, clothing, and access to medical treatment. BF has not been successful in the community due to her leaving board and cares to live in the streets. Upon discharged and being admitted to the CC team, BF was placed in a licensed board and care. Although she leaves her board and care at times, she is able to return home and get her needs met. She has reduced her risk of being victimized in the community and grave disability because she is now able to meet basic needs such as food, personal hygiene, and clothing. BF has recently participated in groups and activities in the community.

II. Please describe ways that the program strives to:

- **a. Reduce mental health stigma**: Telecare CC program uses Telecare's Recovery-Centered Clinical System (RCCS), an innovative recovery framework that incorporates the latest research and evidence-based practices. RCCS emphasizes doing no harm and supporting and enlivening recovery. The recovery model incorporates such approaches as motivational interviewing,

cognitive behavioral therapy, dialectical behavioral therapy (DBT), harm reduction, and other consumer-centered therapeutic interventions.

b. **Create a welcoming environment**: Telecare CC treatment team strives to provide very welcoming and respectful services, utilizing a member-centered, individualized approach emphasizing personal choice and empowerment.

III. **Language Capacity for this program:** English, Spanish, Tagalog

IV. **FY 2018-19 Additional Information:** None

V. **FY 2018-19 Challenges:** Many of our clients are challenging to engage with in the field due to transient behaviors. Limited housing resources and the income of our clients not being enough to cover the daily needs in housing.

VI. **FY 2019-20 Projections of Clients to be Served:** We currently serve 19 partners and inactivated 5 partners in the past year.

VII. **FY 2019-20 Program or Service Changes:** Referring programs are now providing FSP referrals to the CC team, which provides enough information for the team to have successful engagement with our new clients.

GOALS	% of Clients who met Goals
Reduction in Hospital Days	50%
Reduction in Hospital Admits	50%
Reduction in Psychiatric Emergency Services (PES)	50%

A. COMMUNITY SERVICES & SUPPORTS (CSS) PROGRAM SUMMARIES

FY 2019-20 MHSA PLAN UPDATE
COMMUNITY SERVICES & SUPPORTS (CSS) REPORT

FULL SERVICE PARTNERSHIP (FSP) REPORT
FSP # FS12

PROVIDER NAME: Telecare Corporation

PROGRAM NAME: Assisted Outpatient Treatment (AOT) Program

Program Description: AOT is the model connected to AB1421 in California that provides outpatient services for adults with serious mental illness who are experiencing repeated hospitalizations or incarcerations but are not engaging in treatment. The program is built on the Assertive Community Treatment (ACT) model and provides intensive case management, housing assistance, vocational and educational services, medication support and education, co-occurring services, and 24/7 support and availability for crisis.

Target Population: Adults (Age 18 +) who are diagnosed with a severe mental illness, considered to be resistant or reluctant to mental health treatment, who meet the Welfare and Institution Code Criteria as outlined by AB1421.

I. FY 2018-19 Program Outcomes:

a. **Unduplicated Number of Partners Served:** AOT currently serves 22 individuals from the community. The AOT program works one-on-one with our partners to support them with housing, coordinating and accessing medications, job strategies, and mental health services such as psychiatrist visits.

b. **FY 2018-19 Impact:** Based on a recovery-centered model, AOT of Alameda County is an intensive community support service and an Assertive Community Treatment (ACT) for individuals with severe mental illness (SMI), many of whom would otherwise require extended care in institutional settings. AOT serves individuals who are high utilizers of mental health services and who are considered to be at great risk for psychiatric hospitalization. Our multidisciplinary team includes a psychiatrist, a nurse, masters-level clinical staff, vocational specialists, and personal service coordinators who are all here to help individuals in our program on their path.

Client Story: When MH was referred to STRIDES, she was in the verge of being evicted from her apartment and was experiencing extreme paranoia around being “stalked.” MH exhibited assaultive behaviors including spitting on a woman and verbally harassing residents. She was frequently hospitalized for psychiatric reasons. Since working with the AOT, MH is currently living in Lakehurst, managing her finances, attending groups and activities independently. She continues to engage with the AOT team, including her psychiatrist and nurse, and seeking individual therapy.

II. Please describe ways that the program strives to:

a. **Reduce mental health stigma:** AOT uses Telecare’s Recovery-Centered Clinical System (RCCS), an innovative recovery framework that incorporates the latest research and evidence-based practices. RCCS emphasizes doing no harm and supporting and enlivening recovery. The recovery model incorporates such approaches as motivational interviewing, cognitive behavioral therapy, dialectical behavioral therapy (DBT), harm reduction, and other consumer-centered therapeutic interventions.

b. **Create a welcoming environment:** AOT strives to provide very welcoming and respectful services, utilizing a member-centered, individualized approach emphasizing personal choice and empowerment.

III. **Language Capacity for this program:** English, Spanish and Tagalog.

IV. **FY 2018-19 Additional Information:** None

V. **FY 2018-19 Challenges:** Many of our clients are challenging to engage with in the field due to transient behaviors. Limited housing resources and the income of our clients not being enough to cover the daily needs in housing.

VI. **FY 2019-20 Projections of Clients to be Served:** AOT currently serves 23 members and have inactivated 13 in the past year.

VII. **FY 2019-20 Program or Service Changes:** Referring programs are now providing FSP referrals to AOT, which provides enough information for the team to have successful engagement with our new clients.

GOALS*	**% of Clients who met Goals**
Reduction in Hospital Days	33%
Reduction in Hospital Admits	66%
Reduction in Psychiatric Emergency Services (PES)	75%

*These indicators are for clients who have been in a service for 12 months. The indicator is showing a change in the number of events pre service and then 12 months post service initiation.

FY 2019-20 MHSA PLAN UPDATE
COMMUNITY SERVICES & SUPPORTS (CSS) REPORT

FULL SERVICE PARTNERSHIP (FSP) REPORT
FSP # FS13

PROVIDER NAME: Telecare Corporation

PROGRAM NAME: CHANGES

Program Description: Telecare CHANGES is an adult Full Service Partnership located in the Eastmont Town Center in Oakland, CA. The CHANGES FSP provides comprehensive treatment and support services using the Assertive Community Treatment (ACT) service delivery model in which services are delivered by an integrated team including case managers, a vocational specialist, a peer support specialist, a psychiatrist, and a nurse. Services provided by the FSP team include mental health services including individual and group rehabilitation, medication support, nursing support, and targeted case management. The latter service links the individual consumer to needed resources and supports in the community such as housing, benefits, and medical/dental services. Individuals assigned to the CHANGES FSP team can expect to meet with a team member at least twice a week. Additionally, 80% of the team services are delivered in the community.

Target Population: Describe information about consumers'/ clients' age group (i.e., Children/ youth, Transitional Age Youth, Adults or Older Adults; and Partners' unique needs.

The CHANGES FSP serves adult Alameda County residents, 18 years of age or older, with serious mental health conditions or significant functional impairments in one or more major areas of functioning, who are at high risk of re-hospitalization and/or frequent users of acute psychiatric services.

I. **FY 2018-19 Program Outcomes:**
   a. **Unduplicated Number of Partners Served:** 87
   b. **FY 2018-19 Impact:** In FY18-19 as a direct result of the integrated, individualized consumer-driven services and supports provided by the CHANGES FSP, five (5) consumers transitioned to a lower level of service, fifteen (15) new referrals were linked to primary care, four (4) consumers were linked to BALA for assistance getting SSI benefits, eighteen (18) consumers were housed, and sixteen (16) consumers worked with the FSP's vocational specialist during the report period, resulting in one (1) consumer getting a job and two (2) returning to school.

      Two examples of the beneficial impact of CHANGES FSP services are the successes experienced by consumers WC and RB in the past year. Since her enrollment in the FSP team, WC has greatly reduced her utilization of acute services (i.e. mobile crisis, JGPES, criminal justice, etc.): she had 39 acute contacts in 2016, 11 in 2017, 5 in 2018, and none in 2019. In addition, when WC was first referred the CHANGES FSP, she couldn't get a housing interview, let alone an offer of a housing placement due to her history of behavioral outbursts and serious substance use. However, with the support of the FSP team, WC was able to maintain her housing for the entire 12 months of the reporting period. Consumer BR had 15 PES contacts, 6 hospitalizations, and 1 incarceration in 2017-18. Utilizing FSP support and resources he was able to reduce his system utilization to 2 PES contacts, 2 hospitalizations, and 1 incarceration in 2018-19, and his overall total hospital days were much decreased. Furthermore, he went from being chronically homeless, to transitional housing at the Henry Robinson, and ultimately to S+C subsidized permanent housing. As his housing stabilized, RB was able to make use of the linkages created

by the FSP team with primary and specialty healthcare providers, so that he is now receiving much needed medical care for multiple chronic medical conditions.

II. **Please describe ways that the program strives to:**
  a. **Reduce mental health stigma:** The chief instrument employed at CHANGES to reduce mental health stigma is the Recovery-Centered Clinical System (RCCS). RCCS is Telecare's unique wellness and resilience approach that focuses on transforming mental health systems, programs, and individual interactions to awaken and enliven recovery. Because it is steeped in RCCS values and mindful of the negative and harmful impacts of the mental health stigma, the CHANGES program culture constantly seeks to create an environment where individuals' resilience can be expressed. Individual CHANGES FSP staff members are trained in RCCS as well. Additionally, the CHANGES FSP's two Peer Support Specialists share their personal recovery stories as a mean of normalizing a consumer's lived experience, and reducing the internalized stigma attached to having a psychiatric condition and/or receiving mental health services.
  b. **Create a welcoming environment:** The CHANGES offfices are open to consumers from 8:30 am to 5:00 pm. During these hours consumers can drop by, enjoy the spacious socialization room, where they can relax, watch television, play cards, or do art. They have access to coffee, tea, and snacks. They can even get a hot meal. Personal hygiene products are always available to those who need them, as is a supply of donated clothing. The office decor features inspirational sayings throughout. There are two office spaces furnished with computers for consumers to use to access the internet.

III. **Language Capacity for this program:** The CHANGES FSP team has one Vietnamese speaker. In addition, the CHANGES administrative staff includes one Spanish-speaker, and there is a Cantonese-speaker and a Tagalog-speaker on another CHANGES clinical team. The FSP team uses Language Line when necessary to facilitate communication with non-English speaking consumers and/or their families.

IV. **FY 2018-19 Additional Information:** None

V. **FY 2018-19 Challenges:** The greatest challenge faced by the CHANGES FSP during FY 18-19 was the team's two month relocation to another site during October-November. Since the majority of FSP consumers live in East Oakland, San Leandro, and southern Alameda County, moving from East Oakland to downtown Oakland ncreased the distance they had to travel to the FSP office. The increase in travel distance and time resulted in a decrease in client FTF contact due to fewer drop-in clients being seen by case managers, and more missed and cancelled appointments with nurses and prescribers. Staff efforts to compensate for the decrease in proximity to services by increasing field contacts were only partially successful due the increased distance FSP staff had to travel to deliver services to consumers at their homes and in their communities, coupled with the difficulty of being able to consistently locate individual clients. The overall impact of the dislocation was to decrease the team's operational effectiveness and efficiency.

In FY 18-19 the CHANGES FSP also faced many challenges resulting from the expansion of the team's census from 50 to 100 consumers. Most of these challenges were predicatable, and included hiring and training additional staff (the FSP team doubled in size), and securing the many logistical supports needed for the increased staff size, including office space, furniture, computers, phones

and phone lines, etc. There was also a lag in new consumer referrals so that the CHANGES FSP is still 13% below capacity.

Finally, in October, Telecare Corporation adopted a new EHR, swtiching from Caminar to Avatar. As part of implementation the entire CHANGES FSP staff had to be trained up on the new system, while simultaneously continuing to serve consumers. Additionally, during the first few months after roll-out, FSP staff encountered many unanticipated workflow gaps, bottlenecks, and problems with user interface, all of which negatively program efficiency.

VI. FY 2019-20 Projections of Clients to be Served: 100 consumers.

VII. FY 2019-20 Program or Service Changes: None

GOALS	% of Clients who met Goals
Reduction in Hospital Days	70%
Reduction in Hospital Admits	66%
Reduction in Psychiatric Emergency Services (PES)	49%
Partners who received a follow up visit within 2-days after a mental health hospitalization or crisis.	56%
The average of four or more visits per month per client.	67%

FY 2019-20 MHSA PLAN UPDATE
COMMUNITY SERVICES & SUPPORTS (CSS) REPORT

FULL SERVICE PARTNERSHIP (FSP) REPORT
FSP # FS14

PROVIDER NAME: Telecare Corporation

PROGRAM NAME: STRIDES

Program Description: STRIDES is a full service partnership program based on the Assertive Community Treatment model.

Target Population: STRIDES serve individuals with severe mental illness and are high utilizers of mental health services and who are considered to be at great risk for psychiatric hospitalization.

I. FY 2018-19 Program Outcomes:

a. **Unduplicated Number of Partners Served:** Currently STRIDES provides services for 97 members with severe mental health. In addition, STRIDES provided services for 53 members before graduating/stepping them down due to the reconstruction of our program before and on October 1, 2018. Our members are from Alameda County.
b. **FY 2018-19 Impact:** STRIDES continues to engage with our members daily and provide individual rehabilitation, targeted case management services, and medications support. Individual rehabilitation focuses on targeted skills in training for our members in the areas of community living, which include housing stability, self-care, socialization, daily activities, coping skills, symptom management and money management. We communicate with family members and natural supports of our clients and view this as a strength. Our nurses and license providers provide psychoeducation to our team and to our members about the importance of medication issues and coordinate with outside medical providers, hospitals, pharmacies, labs and other health related services. Our nurse collaborates in assessing physical health and coordinating medical and psychiatric treatment for our members. Our vocational specialist provides modeling skills and employment support using the IPS model, to our members who have employment goals. They provide support around job development, benefits counseling, job placement (including going back to school), benefits counseling, and act as a liaison between our members and employees. STRIDES strive to reduce hospitalizations and incarceration by using evidenced base practice techniques and education around crisis management. When clients are in subacute and acute settings, we communicate and collaborate with inpatient team to coordinate the care of our members.

Client Story**:** MB was a community referral from Herrick Hospital. According to her MHA140, MB was going to the Highland and Summit emergency, and John George PES, at least 3-5 times day. She was not connected to any benefits and appeared to be exploited in the community. When she was referred to STRIDES, we immediately outreached to her and open her up in our program within 24 hours. MB presented with memory loss and endorsed delusions and hallucinations of bugs crawling out of her back. Although she was very friendly she informed us that she has never had a place to sleep, however, had a “friend in the community” who gave her money sometimes. She did not want to identify who this friend was and where he lived. She appeared to have poor hygiene and was very disheveled. In the beginning of our engagement, MB did not trust us and often forget who we were. Our team made a plan to see her every day and informed social workers from Summit and Highland to immediately contact us if she self presented at the ER. When received phones calls from the ER, we immediately engaged with MB and provided support with what she needed. We provided her with clothing and food since she did not have access to her SSI. After engaging with her at least 3-4 times a week, she began to trust our

team. She agreed to sign the application to be a part of the substitute payee program and find housing. We viewed several housing options with her until we found a place where MB felt comfortable. Since placing her in the community, she has reduced going to the hospital from 3-5 times a day, every day, to 3-4 times a month. She continues to maintain her housing and is able to engage with STRIDES to get her needs met.

II. **Please describe ways that the program strives to:**
   a. **Reduce mental health stigma:** STRIDES uses Telecare's Recovery-Centered Clinical System (RCCS), an innovative recovery framework that incorporates the latest research and evidence-based practices. RCCS emphasizes doing no harm and supporting and enlivening recovery. The recovery model incorporates such approaches as motivational interviewing, cognitive behavioral therapy, dialectical behavioral therapy (DBT), harm reduction, and other consumer-centered therapeutic interventions.
   b. **Create a welcoming environment:** STRIDES strives to provide very welcoming and respectful services, utilizing a member-centered, individualized approach emphasizing personal choice and empowerment.

III. **Language Capacity for this program:** Language Line, Spanish, Tagalog, and Edo.

IV. **FY 2018-19 Additional Information:** We reconstructed our program in October 2018, which affected our staffing patterns and stepping down and graduating our members.

V. **FY 2018-19 Challenges:** Limitations of Housing resources and income of our clients not being enough to cover daily needs and housing.

VI. **FY 2019-20 Projections of Clients to be Served:** None

VII. **FY 2019-20 Program or Service Changes:** None

GOALS	% of Clients who met Goals
Reduction in Hospital Days	67%
Reduction in Hospital Admits	56%
Reduction in Psychiatric Emergency Services (PES)	42%
Partners who received a follow up visit within 2-days after a mental health hospitalization or crisis.	58%
The average of four or more visits per month per client.	68%

FY 2019-20 MHSA PLAN UPDATE
COMMUNITY SERVICES & SUPPORTS (CSS) REPORT

FULL SERVICE PARTNERSHIP (FSP) REPORT
FSP # FS16

PROVIDER NAME: Seneca Family of Agencies

PROGRAM NAME: Alameda Connections

Program Description: Alameda Connections serves children and their families who are experiencing difficulties in any number of areas including: parent-child relationship problems, at risk of losing school placement, at risk of CPS involvement, and/or behavioral issues with their child. Founded on the Principles of Wraparound, Alameda Connections provides unconditional care that is family centered, individualized, culturally responsive, and strengths-based. Our approach focuses on supporting young children and their families by providing services in the child and family's natural environment, including in the home, at school/daycare, and in the community. Our program hopes to reduce stress for caregivers and facilitate positive, healthy parent/child interactions and relationships; strengthen families by enhancing natural supports and providing help with navigating service systems; provide developmental guidance and behavioral coaching to families to promote healthy development and emotional regulation; connect families to resources in their communities; and provide crisis intervention and concrete assistance with problems of living.

Target Population: Alameda Connections serves the youngest Alameda County children (ages 0-8) who are experiencing difficulties in school and/or may need intensive support services to stabilize.

I. FY 2018-19 Program Outcomes:

a. **Unduplicated Number of Partners Served:** 18
b. **FY 2018-19 Impact:** This year, our program has had a significant impact on the children and families we serve. We have supported several of our clients with finding school placements that appropriately meet their needs, including walking caregivers through the IEP process and supporting them in advocating for their children's needs. Our support counselors have worked tirelessly within several different school systems in order to create individualized plans and teach clients the skills to succeed in the classroom. We have worked in the home to support caregivers create greater structure, consistency and stability for their children, including developing behavioral interventions to address challenging behaviors and creating routines. By providing attunement and validation for the experiences of caregivers, we have seen increased ability of caregivers' abilities to attune to the needs of their children.

   Our program has successfully supported two families to secure housing and we continue to work hard in order to locate and obtain needed housing for our other families in need. We have built relationships with caregivers and worked to build-up caregivers' natural support systems, as well as, strived to coordinate between providers in order to reduce parental stress and excessive appointments. We have connected clients to therapy services and other community services, including legal supports related to housing and educational advocacy. Our staff have walked caregivers' through applications for SSI benefits and other programs to support family stability.

   We're particularly proud of the work we did with a 7-year-old boy and his mother who distrusted the mental health and school systems due to negative previous experiences. Our Care Coordinator spent hours working with client's mother to obtain better housing as the family had

been living in substandard conditions in which mold permeated most of the house. He went to SSI hearings with her in order to help explain what she needed to do in order to receive needed benefits. Our Care Coordinator and Support Counselor worked regularly with the client's school in order to develop intervention plans and to ensure continued placement. Our Support Counselor also worked with the client in the community on his pro-social and regulation goals. Our Care Coordinator provided regular coaching to client's mother on how to regulate herself when triggered and how to communicate effectively with client. Although we were only able to find them housing outside of Alameda County, our team worked relentlessly with mom to transition services to the new county, including client's IEP to a new school district, their housing subsidy, Medi-cal benefits, and therapy services. Finally, although mom had been initially opposed to inviting her natural supports to Family Team Meetings (FTM), at the last transition FTM, this mother invited several family members (Aunt, Uncle, Cousin) to help plan how they could continue supporting client and family after the Wrap program closed.

II. Please describe ways that the program strives to:

a. Reduce mental health stigma: Our program works to reduce stigma related to mental health by providing services on our clients' terms – in the community and during flexible times to meet the needs of our children and families. We work very hard to focus on the families' goals for services and build relationships through the delivery of practical/tangible support (financial, transportation, etc.). For some families, we provide a Family Partner who has personally experienced challenges with their own children (CPS, IEPs, etc.) in ordert to validate the caregivers' experiences and show them that receiving mental health support is valuable.

b. Create a welcoming environment: In order to create a welcoming environment, we work to meet families where they are most comfortable – in their own home, at a public park, or a coffee shop. We regularly offer to bring food to appointments in order to create a sense of community and safety. We strive to have a diverse staff team in order to be able to reflect the diversity of our client population. Our staff works to talk openly about issues of difference, systemic oppression, and to validate the experiences of our often marginalized children and families.

III. Language Capacity for this program: Our program has the capacity to deliver services in English and Spanish.

IV. FY 2018-19 Additional Information: <u>None</u>

V. FY 2018-19 Challenges: The lack of affordable housing for low-income families is probably the biggest barrier our program faces. Additionally, although our program worked successfully in many school systems, we found that gaining entry and collaboration with 1-2 schools was very difficult. Finding affordable and flexible daycare/childcare that is willing and able to serve children with special needs (trauma, behavioral challenges, etc.) has also been a challenge the program has faced. We've had difficulty recruiting and hiring a full-time Family Partner. Lastly, complex intergenerational trauma in families, as well as their negative experiences with previous "systems" has also been a barrier to relationship-building and lasting parent-child transformation.

VI. FY 2019-2020 Projections of Clients to be Served: 20

VII. FY 2019-20 Program or Service Changes: <u>None</u>

FY 2019-20 MHSA PLAN UPDATE
COMMUNITY SERVICES & SUPPORTS (CSS) REPORT

GOALS	% of Clients who met Goals
% of FSP clients who receive 1 "face-to-face" visit within 7 calendar days of their episode opening date.	28%
The average of four or more visits per month per client.	81%
Partners who received a follow up visit within 2-days after a mental health hospitalization or crisis.	No qualifying events

FY 2019-20 MHSA PLAN UPDATE
COMMUNITY SERVICES & SUPPORTS (CSS) REPORT

FULL SERVICE PARTNERSHIP (FSP) REPORT
FSP # FS17

PROVIDER NAME: Fred Finch Youth Center

PROGRAM NAME: East Bay Wrap FSP

Program Description: East Bay Wrap provides Wraparound services to youth and their families in the community. The aim of the service is to promote wellness, self-sufficiency, and self-care/healing to youth who live in Alameda County, receive Alameda County Medi-Cal, and have met the entry criteria for services.

Target Population: East Bay Wrap-FSP serves youth aged 8-18. The entry criteria include having repeated or recent hospitalizations; or having at least 2 of the following: Failed multiple appointments with past providers; School absenteeism; Risk of homelessness; High score for trauma on CANS or Lack of significant progress in Therapeutic Behavioral Services (TBS).

I. FY 2018-19 Program Outcomes:

a. **Unduplicated Number of Partners Served:** 21

b. **FY 2018-19 Impact:** The program officially began operations receiving referrals from ACCESS on October 12, 2018 and our first participant began services Oct 23rd. We had an average of 3 openings per month between November and May when we reached our capacity of 20 enrollees.

Client Story: One client has been open with us since January and the family has been working closely with Wraparound and TBS. When the youth started, they were presenting with physical and verbal aggression at home/school and extreme social anxiety. However, the youth and family has been engaging in services and the youth has been thriving over the summer, making new friends at her summer camp, using coping skills, and expressing feelings at home. The youth is getting along much better with their mother and is being open to trying new experiences too.

II. Please describe ways that the program strives to:

a. Reduce mental health stigma: FFYC maintains a longstanding philosophy that the best road to change is one that is family-centered and strength-based. Staff understands that healthy changes are possible but can be difficult to implement. We try to meet our youth and family where they are at in terms of readiness to change. In addition, we use trauma-informed practice. We often see that behavioral challenges are a manifestation from unresolved trauma. We invite dialogue, treatment strategies and psycho-education to help the youth, family and treatment team better understand the impact of trauma on how the youth is presenting.

b. Create a welcoming environment: An essential feature of service is employing an unconditional commitment to positive outcomes, strengths-based and a “whatever-it-takes” planning strategy. Through building trust and helping address unmet needs, families often see small improvements in their well-being. We encourage families and youth to voice their preferences and priorities and from this, convey that we respect and see them as experts in their lives. All staff are participating in Affinity Groups where we are discussing and putting into action, ideas to be more aware of the impact of race and privilege in our personal and professional lives. We anticipate that this awareness will have a positive impact on creating a welcoming environment for our families.

III. Language Capacity for this program: We have a Spanish speaking Youth Partner on our team.

IV. FY 2018-19 Additional Information: This is our first year in operation. Our department at FFYC swiched our Electronic Health Record keeping system in April of 2019.

V. FY 2018-19 Challenges: Since this was our first year in operation, we had several challenges to address. The main one was staffing. Hiring at a non-profit in an ever-growing unaffordable location is becoming more complex. We have found that it takes more time to bring in high quality candidates to all positions at our agency. We hired an internal staff to the position of Clinical Supervisor who came with extensive Quality Assurance experience. We added the first clinician to the team in November and the second one started in April. Both are licensed. Our Youth Partner started in May and we completed our team with a Parent Partner in June. Prior to having a full team, staff assisted from other parts of the department. We hope that with having a full team, this issue will be less pronounced in the coming fiscal year.

VI. FY 2019-20 Projections of Clients to be Served: Maintain 20 enrollees.

VII. FY 2019-20 Program or Service Changes: We will be completing MAA's which will add new paperwork and tracking to staff's workload demands.

GOALS	% of Clients who met Goals
% of FSP clients who receive 1 "face-to-face" visit within 7 calendar days of their episode opening date.	14%
The average of four or more visits per month per client.	65%
Partners who received a follow up visit within 2-days after a mental health hospitalization or crisis.	68%

FY 2019-20 MHSA PLAN UPDATE
COMMUNITY SERVICES & SUPPORTS (CSS) REPORT

FULL SERVICE PARTNERSHIP (FSP) REPORT
FSP # FS18

PROVIDER NAME: Bay Area Community Services

PROGRAM NAME: Homeless Engagement Action Team (HEAT)

Program Description: Contractor shall provide full service partnership services within the philosophy of 'whatever it takes' to Alameda County homeless adult residents who live with serious mental illness. Clients shall be those individuals at high risk of re-hospitalization who could live in the community if comprehensive services and concentrated supports were available to accommodate their needs.

Target Population: Clients will include individuals who are homeless or at risk of homelessness, have been involved in the criminal justice system, have co-occurring substance use and / or physical health disorders, frequently use hospitals and other emergency services, are at risk of institutionalization, and / or have limited English proficiency. Contractor shall serve individuals who are sex offenders.

I. **FY 2018-19 Program Outcomes:**
   a. **Unduplicated Number of Partners Served:** 77
   b. **FY 2018-19 Impact:** 77 Partners were served

II. **Please describe ways that the program strives to:**
   a. **Reduce mental health stigma:** As part of the FSP program, and MHSA principles, BACS hires a peer and family partner workforce that ensures that mental health stigma is eradicated from its service delivery system. BACS partners with NAMI, FERC, POCC, and Office of Consumer Empowerment to fight and eradicate the stigma associated with mental illness.
   b. **Create a welcoming environment:** BACS utilizes the Welcoming Toolkit that was created by BHCS over five years ago and has an in-house design team to ensure all program locations are welcoming, warm, vibrant, colorful, culturally inclusive, and responsive as well as accessible. BACS has consumer councils for the decorating of the centers. All sites and locations ensure that money is spent on keeping the facilities modern, warm, and inclusive. Additionally, Lavender Seniors certified BACS's sites as LGBTQ inclusive.

III. **Language Capacity for this program:** English, Spanish, Cantonese. Additionally, BACS access to all threshold languages in-house through BACS' bilingual pool of on-call staff.

IV. **FY 2018-19 Additional Information:** HEAT implemented Assertive Community Treatment (ACT) evidence-based practices (EBP's) as a model of care which includes daily ACT meetings every morning, tracking staff's engagement with clients through a comprehensive meeting log and implementing the following EBP's associated with ACT through direct services employees: IDDT/SA specialist, IMR/Peer Specialist, IPS/Employment Specialist, Crisis, Case management, psych rehab, homelessness/supporting housing services.

    Given that HEAT serves a majority of homeless clients, of the 77 clients served in our 3rd and 4th quarters we have successfully found housing solutions (temporary/transitional/permanent housing) for approximately 70 clients. Employing the housing first philosophy has led to our clients having decreased the revolving cycle of psychiatric hospitalizations, ED visits, and incarcerations.

Our Employment Specialist has a current caseload of 10 clients that are engaged in competitive employment or are actively seeking employment.

V. FY 2018-19 Challenges: One of HEAT's challenges continues to be related to the Bay Area Housing crisis, acutely felt in Oakland where a majority of our clients live. This coupled with the rise in cost of living and our client's fixed incomes, often SSI has created some barriers to HEAT finding appropriate and sustainable housing placements that will meet our client's unique needs. Given that HEAT is charged with serving chronically and literally homeless adults, the expectations of immediate permanent housing versus the reality of lack of affordable housing often come into stark contrast and managing client or community partner expectations around this fact is a constant practice.

Another challenge has been around orienting staff to the ACT model and program philosophy as many staff had not previously worked on an ACT team. However, as a new director joining the team in April, I have seen remarkable progress and growth from all the members of HEAT!

VI. FY 2019-2020 Projections of Clients to be Served: 150 partners.

VII. FY 2019-20 Program or Service Changes: HEAT will expand by 50 partners this fiscal year.

GOALS	% of Clients who met Goals
Reduction in Hospital Days	N/A*
Reduction in Hospital Admits	N/A*
Reduction in Psychiatric Emergency Services (PES)	N/A*
Partners who received a follow up visit within 2-days after a mental health hospitalization or crisis.	56%
The average of four or more visits per month per client.	79%

* This is a new program, no clients have been in the program for 12 months to look at reductions past the 12 month service mark.

FY 2019-20 MHSA PLAN UPDATE
COMMUNITY SERVICES & SUPPORTS (CSS) REPORT

FULL SERVICE PARTNERSHIP (FSP) REPORT
FSP # FS19

PROVIDER NAME: Bay Area Community Services

PROGRAM NAME: Circa60

Program Description: Contractor shall provide full service partnership services within the philosophy of 'whatever it takes' to Alameda County older adults who are homeless and who live with serious mental illness. Clients shall be those individuals at high risk of re-hospitalization who could live in the community if comprehensive services and concentrated supports were available to accommodate their needs.

Target Population: Clients shall be older adults (age 60+) who are homeless or at risk of homelessness and will include those who have been involved in the criminal justice system, have co-occurring substance use and / or physical health disorders, frequently use hospitals and other emergency services, are at risk of institutionalization, and / or have limited English proficiency. Contractor shall serve individuals who are sex offenders.

I. **FY 2018-19 Program Outcomes:**
   a. **Unduplicated Number of Partners Served:** 95
   b. **FY 2018-19 Impact:** 95 partners were served.

II. **Please describe ways that the program strives to:**
   a. **Reduce mental health stigma:** As part of the FSP program, and MHSA principles, BACS hires a peer and family partner workforce that ensures that mental health stigma is eradicated from its service delivery system. BACS partners with NAMI, FERC, POCC, and Office of Consumer Empowerment to fight and eradicate the stigma associated with mental illness.
   b. **Create a welcoming environment:** BACS utilizes the Welcoming Toolkit that was created by BHCS over five years ago and has an in-house design team to ensure all program locations are welcoming, warm, vibrant, colorful, culturally inclusive, and responsive as well as accessible. BACS has consumer councils for the decorating of the centers. All sites and locations ensure that money is spent on keeping the facilities modern, warm, and inclusive. Additionally, Lavender Seniors certified BACS's sites as LGBTQ inclusive.

III. **Language Capacity for this program:** English, Spanish. Additionally, BACS access to all threshold languages in-house through BACS' bilingual pool of on-call staff.

IV. **FY 2018-19 Additional Information:** At the end of the fiscal year our team has been referred 95 partners and is working to open all for services. We continue to improve the ability of our partners to achieve and maintain an optimal level of functioning and recovery by providing supportive case management and wrap around services. Our team is able to respond quickly and efficiently to emergent partner needs. Numerous times over the past six months, a partner would have an increase in mental health symptoms and problematic behaviors that jeopardized housing and overall well-being. By responding rapidly and increasing partner contact we were able to intervene, help stabilize our partner's symptoms and prevent crisis before they happen. We have also have built an effective and responsive relationships with many of our partner's landlords and housing managers. We use these relationships to help maintain and avoid disruptions in in housing. Circa60

team members work with all our partners to identify areas of interest and help develop engagement in meaningful activities. We also worked hard to identify and build natural supports for many of our partners.

Over the past six months we've enjoyed helping our partners living better and more fulfilling lives. One particular success story involved a chronically homeless partner that is well known to the community and has historically been difficult serve. He was hospitalized at John George in May 2019. Feeling this was our opportunity, our team work hard with the partner and his family to locate and secure a bed at licensed board and care. Once the partner moved in, we were able see him multiple times per week to help with the transition and to assist him in the community. As of this report the partner has continued to thrive and is adjusting well to his new home.

As we grow as an FSP we've continue to develop infrastructure and practices to meet the high-fidelity Assertive Community Treatment (ACT) evidence-based practice standards. This includes running a morning ACT meeting, developing and using an on-line daily log to track activities and increasing partner engagement and working to improve all our team's efforts.

V. **FY 2018-19 Challenges:** During this fiscal year Circa60 has faced numerous challenges as our program grows and develops. One of these includes finding appropriate licensed board and care homes for our partners needing this level of care but only on a minimum SSDI or not making enough money to afford Alameda County rates. In these circumstances we are left housing partners in sub-optimal living arrangements and increasing our weekly contacts and working to get IHHS started. Overall housing and keeping some of our partners stably housed has been a challenge.

VI. **FY 2019-2020 Projections of Clients to be Served:** 100 Partners.

VII. **FY 2019-20 Program or Service Changes:** None

GOALS	% of Clients who met Goals
Reduction in Hospital Days	63%
Reduction in Hospital Admits	62%
Reduction in Psychiatric Emergency Services (PES)	69%
Partners who received a follow up visit within 2-days after a mental health hospitalization or crisis.	39%
The average of four or more visits per month per client.	34%

FY 2019-20 MHSA PLAN UPDATE
COMMUNITY SERVICES & SUPPORTS (CSS) REPORT

FULL SERVICE PARTNERSHIP (FSP) REPORT
FSP # FS20

PROVIDER NAME: Bay Area Community Services

PROGRAM NAME: Lasting Independence Forensic Team (LIFT)

Program Description: Contractor shall provide full service partnership services within the philosophy of 'whatever it takes' to Alameda County adult residents who have been involved with the criminal justice system and live with serious mental illness. Clients shall be those individuals at high risk of re-hospitalization and/or reincarceration who could live in the community if comprehensive services and concentrated supports were available to accommodate their needs.

Target Population: Clients shall be adults who have been involved with the criminal justice system and will include individuals who are homeless or at risk of homelessness, have co-occurring substance use and / or physical health disorders, frequently use hospitals and other emergency services, are at risk of institutionalization, and / or have limited English proficiency. Contractor shall serve individuals who are sex offenders.

I. **FY 2018-19 Program Outcomes:**
   a. **Unduplicated Number of Partners Served:** 71
   b. **FY 2018-19 Impact:** 71 Partners were served.

II. **Please describe ways that the program strives to:**
   a. **Reduce mental health stigma:** As part of the FSP program, and MHSA principles, BACS hires a peer and family partner workforce that ensures that mental health stigma is eradicated from its service delivery system. BACS partners with NAMI, FERC, POCC, and Office of Consumer Empowerment to fight and eradicate the stigma associated with mental illness.
   b. **Create a welcoming environment:** BACS utilizes the Welcoming Toolkit that was created by BHCS over five years ago and has an in-house design team to ensure all program locations are welcoming, warm, vibrant, colorful, culturally inclusive, and responsive as well as accessible. BACS has consumer councils for the decorating of the centers. All sites and locations ensure that money is spent on keeping the facilities modern, warm, and inclusive. Additionally, Lavender Seniors certified BACS's sites as LGBTQ inclusive.

III. **Language Capacity for this program:** English, Spanish. Additionally, BACS access to all threshold languages in-house through BACS' bilingual pool of on-call staff.

IV. **FY 2018-19 Additional Information:** LIFT has implemented Assertive Community Treatment (ACT) evidence-based practices to our team, including daily ACT meetings every morning. The team has been receiving on going training for infrastructure development for high fidelity and is prepared for baseline review.

    We have been able to house partners successfully in shared housing where they are able to build community and natural supports. Having housing stability has led to our partners having a decreased number of crisis interventions, hospitalizations and incarcerations.

A majority of our partners are connected with financial benefits, those that aren't, are in the application process currently and will be connected with community resources such as the Homeless Action Center and Bay Area Legal Aid should they be denied financial benefits.

V. **FY 2018-19 Challenges:** One of the challenges LIFT has been faced with is connecting our partners that do not have financial means to connect to SSI/SSDI benefits. This has been particularly true for partners that have a difficult time consistently engaging due to lack of stability. The team is consistently working on building rapport and improve engagement efforts to support the partners.

Another challenge has been finding appropriate housing placements due to lack of housing in the community, particularly licensed board and care homes that meet the needs of our partners and those which the partners are able to afford due to their fixed monthly income.

VI. **FY 2019-2020 Projections of Clients to be Served:** 100 partners.

VII. **FY 2019-20 Program or Service Changes:** None

GOALS	% of Clients who met Goals
Reduction in Hospital Days	N/A*
Reduction in Hospital Admits	N/A*
Reduction in Psychiatric Emergency Services (PES)	N/A*
Partners who received a follow up visit within 2-days after a mental health hospitalization or crisis.	53%
The average of four or more visits per month per client.	59%

* This is a new program, no clients have been in the program for 12 months to look at reductions past the 12 month service mark.

FY 2019-20 MHSA PLAN UPDATE
COMMUNITY SERVICES & SUPPORTS (CSS) REPORT

FULL SERVICE PARTNERSHIP (FSP) REPORT
FSP # FS21

PROVIDER NAME: Bay Area Community Services

PROGRAM NAME: Prevention, Advocacy, Innovation, Growth, and Empowerment (PAIGE)

Program Description: Contractor shall provide full service partnership services within the philosophy of 'whatever it takes' to Alameda County Transition Age Youth (TAY) who live with serious mental illness. Clients shall be those individuals at high risk of re-hospitalization who could live in the community if comprehensive services and concentrated supports were available to accommodate their needs.

Target Population: Clients will include TAY individuals who are homeless or at risk of homelessness, have been involved in the criminal justice system, have co-occurring substance use and / or physical health disorders, frequently use hospitals and other emergency services, are at risk of institutionalization, and / or have limited English proficiency. Contractor shall serve individuals who are sex offenders.

I. FY 2018-19 Program Outcomes:
   a. **Unduplicated Number of Partners Served:** 37
   b. **FY 2018-19 Impact:** 37 Partners were served.

II. Please describe ways that the program strives to:
   a. **Reduce mental health stigma:** As part of the FSP program, and MHSA principles, BACS hires a peer and family partner workforce that ensures that mental health stigma is eradicated from its service delivery system. BACS partners with NAMI, FERC, POCC, and Office of Consumer Empowerment to fight and eradicate the stigma associated with mental illness.
   b. **Create a welcoming environment:** BACS utilizes the Welcoming Toolkit that was created by BHCS over five years ago and has an in-house design team to ensure all program locations are welcoming, warm, vibrant, colorful, culturally inclusive, and responsive as well as accessible. BACS has consumer councils for the decorating of the centers. All sites and locations ensure that money is spent on keeping the facilities modern, warm, and inclusive. Additionally, Lavender Seniors certified BACS's sites as LGBTQ inclusive.

III. Language Capacity for this program: English, Spanish. Additionally, BACS access to all threshold languages in-house through BACS' bilingual pool of on-call staff.

IV. FY 2018-19 Additional Information: Since the launch of PAIGE in November 2018, PAIGE has served 37 youth. Many of the youth have shown a significant reduction in mental health symptoms, improvement in interpersonal and communication skills and an increase in engagement, since receiving support from the PAIGE team. Many of the youth that struggled to engage in meaningful activities are engaging in community outings and events and establishing social connections with other peers.

PAIGE has supported many clients in taking a big step in achieving educational and employment goals. PAIGE has supported clients by enrolling them in GED/diploma programs, community college, security card classes, CPR/AED/First Aid Certification classes and a 4-week intensive job readiness

program and food handlers certification classes. 16 of the youth have been referred to receive employment services and 4 are currently employed.

Many of our youth have successfully gained meaningful employment, holding jobs in restaurants, construction, security, warehouse work, babysitting, animal care, retail, crafting, management, and customer service. Our youth value the community and peer supportive resource we provide through peer groups and socials where they develop enhanced social skills, mindfulness tools, coping skills, while gaining support from other youth experiencing similar challenges; this reduces youth isolation and enhances social network and positive relationship skill development, and conflict resolution skills.

V. **FY 2018-19 Challenges:** One of the challenges was receiving appropriate referrals in the areas contracted. A remedy for this challenge was to extend service locations.

Another challenge PAIGE experienced this fiscal year was locating and maintaining contact with a few referrals. Staff exhausted all efforts in locating clients and providing support, but at times staff found it difficult establishing contact with a few clients. The PAIGE team has and will continue to work with other providers to ensure contact is made and maintained with every client opened to the program.

VI. **FY 2019-20 Projections of Clients to be Served:** 50 partners.

VII. **FY 2019-20 Program or Service Changes:** None

GOALS	% of Clients who met Goals
Reduction in Hospital Days	N/A*
Reduction in Hospital Admits	N/A*
Reduction in Psychiatric Emergency Services (PES)	N/A*
Partners who received a follow up visit within 2-days after a mental health hospitalization or crisis.	48%
The average of four or more visits per month per client.	55%

*This is a new program, no clients have been in the program for 12 months to look at reductions past the 12 month service mark.

FY 2019-20 MHSA PLAN UPDATE
COMMUNITY SERVICES & SUPPORTS (CSS) REPORT

FULL SERVICE PARTNERSHIP (FSP) REPORT
FSP # FS22

PROVIDER NAME: Telecare Corporation

PROGRAM NAME: Justice and Mental Health Recovery (JAMHR)

Program Description: JAMHR is a Justice-involved FSP that utilizes the Assertive Community Treatment (ACT) evidenced-based model of care. JAMHR services include but are not limited to:

- Outreach and engagement
- Behavioral health screenings and assessments
- Individualized recovery planning
- Intensive case management to address behavioral health needs and criminogenic factors
- Crisis intervention
- Medication support
- Housing services
- Family support
- Vocational services using the IPS model
- Linkage to substance use treatment and medical care
- Collaboration with the justice system
- 24/7 On-call staff to respond in the community

Target Population: Partners of Alameda County Behavioral Health who are diagnosed with serious mental illness and have justice involvement. We are able to serve partners aged 18 and up but the majority of our partners are over age 25.

I. **FY 2018-19 Program Outcomes:**
   a. **Unduplicated Number of Partners Served:** 81 unduplicated partners; 52 admission and 29 outreach pending admission
   b. **FY 2018-19 Impact:** JAMHR successfully engaged and admitted 52 new partners.
      - Successfully transition partners of the FACT/TRACT and BOSS programs after their closures.
      - Outreached to new referrals in many settings, including: Santa Rita Jail, Atascadero State Hospital, John George Crisis Stabilization and Inpatient Units, Villa and Flex, Gladman, Cherry Hill, Level 1 Case Management Programs, Behavioral Health Court, Drug Court, Family homes
      - Helped partners identify risks and strengths and utilized that information to co-create treatment plans based on partner goals
      - Supported partners to decrease homelessness, medical hospitalizations, psychiatric hospitalizations and re-incarcerations.
      - Linked partners to medical care and substance use treatment.
      - Collaborated with families to increase partner support and opportunities for success in the community.
      - Provided 22 partners with vocational services resulting in job interviews, linkage to GED programs and community college, and acceptance to BestNow Peer Training program.
      - Our offices are located in downtown Oakland and are easily accessible by public transportation. A minimum of 80% of our services are provided directly in the community.

FY 2019-20 MHSA PLAN UPDATE
COMMUNITY SERVICES & SUPPORTS (CSS) REPORT

Client Story: "Frederick" joined the JAMHR program in April, 2019 when he was released from jail on arson related charges. He has a diagnosis of Schizoaffective disorder, bipolar type and symptoms of a cluster B personality disorder. He had 163 contacts with ACBH since 1985. He initially presents as intelligent and organized, but reacts to perceived stressors with extreme emotions, impulsivity, elevated mood, pacing, restlessness, paranoia and aggression and he admits to purposely committing crimes to get himself incarcerated, where he feels safest. JAMHR team has had an average of 5-6 contacts per week with Frederick since April, educating him on grounding techniques, emotion regulation, risk management and teaching him how to identify true crises vs. perceived crises. During this period he went to John George Crisis Stabilization once, and was arrested in Contra Costa County once. Nonetheless, we concurrently engaged him with IPS vocational services according to his stated goal to be a peer counselor. He went through the application and interview process to take peer specialist training at the BestNow program in Oakland, and he was just invited to join their next class to learn to be a trained peer specialist, starting in the fall of 2019!

II. **Please describe ways that the program strives to:**

   a. **Reduce mental health stigma:** We utilize a person-centered approach to engage with our partners. We treat everyone as individuals and help them identify their strengths. We provide psychoeducation so that partners can learn about their symptoms without self-blame. We educate our community partners (such as: medical providers, housing operators, families, etc.) about how to treat partners with dignity and respect. Most importantly, we empower our partners to learn new skills that help them increase their independence and self-esteem.

   b. **Create a welcoming environment:** We treat partners with dignity and respect, whether we meet them at our office or in the community. Staff have ongoing trainings about providing person-centered care, cultural awareness, reducing stigma and recognizing individual uniqueness and strengths, so partners feel welcome where ever we meet them. We celebrate successes with our partners!

III. **Language Capacity for this program:** Spanish and Urdu in Vivo. We regularly use language line to provide linguistically appropriate services to those who speak other languages.

IV. **FY 2018-19 Additional Information:** None

V. **FY 2018-19 Challenges:** JAMHR opened in October 2018. We went from 0 to 52 partners. When we opened, our team was very knowledgeable about behavioral health services, but needed to learn about the justice involved system. We increased our knowledge about homeless resources, substance use treatment resources and benefits supports as well.

VI. **FY 2019-20 Projections of Clients to be Served:** Projected to fill our 100 slots by the end of the 2019/2020 year. Once we are full, we will plan to step down about 5% of partners to make room for new referrals.

VII. **FY 2019-20 Program or Service Changes:** As a growing program, we were not fully staffed by the end of 2018/2019 year. We expect to be fully staffed by the end of 2019. We plan to increase substance use services, including adding Seeking Safety groups and co-occurring groups for people in the pre-contemplation and contemplation stages of change.

FY 2019-20 MHSA PLAN UPDATE
COMMUNITY SERVICES & SUPPORTS (CSS) REPORT

GOALS	% of Clients who met Goals
Reduction in Hospital Days	N/A*
Reduction in Hospital Admits	N/A*
Reduction in Psychiatric Emergency Services (PES)	N/A*
Partners who received a follow up visit within 2-days after a mental health hospitalization or crisis.	64%
The average of four or more visits per month per client.	88%

* This is a new program, no clients have been in the program for 12 months to look at reductions past the 12 month service mark.

FY 2019-20 MHSA PLAN UPDATE
COMMUNITY SERVICES & SUPPORTS (CSS) UPDATE REPORT

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 4A

PROVIDER NAME: City of Fremont

PROGRAM NAME: Mobile Integrated Assessment Team for Seniors

Program Description: Clients are offered a range of outpatient mental health services including individual, family and group therapy, medication management, case management and crisis services. As clients become more stable they can join a step-down program that supports resiliency and recovery prior to discharge from program. Some clients are trained to become peer coaches to support other clients in need of social inclusion and support.

Target Population: Older Adults (60 years or older) living in the Tri-City area (Fremont, Union City, Newark) or Hayward with moderate to severe mental health diagnosis. Clients also have complicated health conditions with almost 50% of clients having arthritis, 30% with hypertension, 25% with diabetes and high cholesterol.

I. FY 2018-19 Outcomes:

a. **Number of unique consumers/clients served:** 55
b. **FY 2018/19 Impact:**
   - The ultimate goal of the program is to provide services to the recovery of our clients. The program helps many clients in successfully meeting their desired treatment goals thus giving clients the mental and emotional stability they need and regaining independence. Gaining stability relieves stress in the family and once client recovers family recovers as well and family becomes an invaluable resource for the clients. The program provides family therapy and other supportive services and the program staff works with them through diagnosis and beyond.
   - Clients with mental illness have identity and voice, so the program engages them in an open and honest discussion when it comes to their own treatment and we recognize and praise their strengths and progress.
   - Clients diagnosed today can expect better outcome than before ie: medication have improved and new evidence based psychotherapeutic interventions can have powerful and positive effects on client's recovery per our psychiatrist and Physician Assistant.
   - The program population suffers from multiple medical and physical challenges directly impacting their mental health condition and vice versa. This situation calls for increased service collaboration with client's primary care providers and other specialized medical services which is outside the program scope of services.
   - The program develops a wide range of community support services to address the diverse needs of the program population.
   - The program supports on-going professional staff development including trainings to advance staff's knowledge/understanding of different culture of the client (cultural competency trainings).
   - City of Fremont- as a city organization actively engages mental health advocacy efforts toward increasing community awareness aimed at reducing stigma associated with mental illness.
   - The impact of stigma and misconception make people reluctant to seek help.

FY 2019-20 MHSA PLAN UPDATE
COMMUNITY SERVICES & SUPPORTS (CSS) UPDATE REPORT

II. Please describe ways that the program strives to:

a. **Reduce mental health stigma:** Unfortunately, clients living with mental illness still experience stigma and misconception – a difficult reality. As we all know, stigma surrounding mental illness makes people reluctant to seek professional help.
   - The program provides on –going psychoeducation to clients and families, community and other service providers about mental health and the importance of seeing our clients beyond their mental illness. By knowing client's diagnosis and symptoms associated with illness, they can better prepare plans to deal with the problem that may arise
   - The program actively participates in various mental health awareness events
   - Challenge people's myths and stereotype about mental illness via health promoting efforts.
   - The program focuses more on the positive side of the clients, that people with mental illness make valuable contributions to our community
   - Collaborate and coordinate services with advocacy groups such as NAMI, Family Education Resource Center (FERC), and other city programs and join these groups to speak against stigma
   - Living with mental illness is already challenging and the added stigma leads to poor treatment outcome. The more we talk about mental illness the more normalized it become
   - The City of Fremont –Human Services Department actively engages state level policy development impacting mental health services for our clients

b. **Create a welcoming environment:**
   - The City of Fremont created a safe and tolerant environment free of prejudice and discrimination
   - The program provides protective factors for clients giving them a sense of belonging, positive climate and easy access to supportive services
   - The program ensures that our clients can get to and from the program with ease, so they don't feel isolated and can maintain connection to the facility
   - All City programs display valuable community resources available to all clients
   - The program has trained senior peer coaches who have lived experiences and have unique skills set that draws the lived experiences of recovery as their expertise. They offer their recovery lessons as a gift to others
   - The city of Fremont actively participates in the annual Gay Pride celebration
   - The City of Fremont has disabled access and provides free parking for clients
   - City of Fremont staff wears badges displaying their names to encourage contact
   - The City Fremont makes sure we provide a cheerful environment by displaying different art work with colors
   - Display poster of the Alameda County Behavioral Health Care Services (Mission, Vision and Values)

III. Language Capacity for this program: Spanish, Tagalog, Hindi, Farsi, Cantonese /Mandarin, Sign language through Partners in Communication Agency. If there is a need for a specific language not listed above, the program uses other staff with that language capacity from other Human Services Programs or uses the on-line translation.

IV. FY 2018-19 Additional Information: None

FY 2019-20 MHSA PLAN UPDATE
COMMUNITY SERVICES & SUPPORTS (CSS) UPDATE REPORT

V. FY 2018-19 Challenges: Given the population we serve, our seniors are now experiencing more losses in their lives, including losing their significant others and other love ones, losing their health (medical, physical, vision, hearing etc.) losing some level of their independence, (can no longer drive) or problems with mobility including falls and clients who are now experiencing early onset of dementia. These factors have significant impact on clients reaching needed stability and functioning as they are now needing more care and support from their own families and other specialty care providers**.**

Our clients struggle to find affordable housing in the Tri-City areas. We have a client who was awarded Section 8 Housing last summer and up to this date, she has not been able to find housing that accepts section 8 Certificate. The client lost her section housing certificate. Legal Assistance for Senior is advocating for client to re-instate her section 8 housing certificate. With their low and fixed monthly income, they are feeling pressured to look for housing outside Alameda County which easily triggers their symptoms thus impacting their stability and functioning**.**

Client's language, culture, religion and the going stigma attached to mental illness continues to serve as a barrier to help seeking behavior. In addition, increasing medical issues/diagnosis and physical challenges are reasons that set them back in successfully meeting their mental health treatment goals? Lastly, the above obstacles prevent them from fully utilizing community resources and increasing their level of isolation.

Frequent appointment cancellations due to medical and physical reasons are also major obstacles in successfully meeting their treatment goals.

Many clients will discontinue staying on medication without first consulting with the prescribing physician. Staff provides on-going psycho-education to clients re: importance of staying on medication and consulting with the prescriber before stopping their medication.

The LGBT program continues to experience difficulties meeting its program goals. Despite extensive community outreach and health promoting efforts to increase client's admission to the program, there has not been a response from partner's organizations, family members and the community. Plan is to restructure our health promoting and marketing strategies to reach this population.

VI. FY 2019-20 Projections of Clients to be Served:

- Senior Mobile Mental Health: To serve 55 clients
- Recovery and Resiliency Program: To serve 10-12 clients

VII. FY 2019-20 Program or Service Changes: None

FY 2019-20 MHSA PLAN UPDATE
COMMUNITY SERVICES & SUPPORTS (CSS) UPDATE REPORT

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 5A

PROVIDER NAME: Alameda County Behavioral Health (ACBH)

PROGRAM NAME: Crisis Response Program: (South County), plus Community Based Voluntary Crisis Services Transition to Mobile Crisis Team (MCT) & Mobile Evaluation Teams (MET)

Program Description: Crisis Response Program (CRP) has been an outpatient clinic that provides brief mental health services including case management, targeted crisis therapy, and psychiatry. On average, participants remain in the program for 30-90 days. Once stabilized, participants are transferred to a level of care most appropriate to meet the participant's needs. Consumers who may not need specialty mental health services but need to be connected to a lower level of care such as primary care, substance use treatment, and other community services are also evaluated and referred. The functions of assessing and referring clients to the most appropriate level of behavioral health care transferred to the ACCESS department of ACBH effective January 2019.

The Mobile Crisis Team (MCT) responds to 5150/5585 and other crisis calls from police, shelters, designated commuinty agencies, and community members for individuals of all ages. Clinicians conduct a psychiatric and risk assessment which is used to determine the best intervention and linkage to services for that indivdual at that time. The Mobile Evaluation Team (MET) consists of a police officer with an ACBH clinician. They provide the same assessment, intervention, and linakge to services as the MCT however they respond to calls from police dispatch.

In January 2019 CRP transitioned from providing outpatient clinic services to focusing on Mobile Crisis Services, with all CRP clinical staff working primarily in the field. The expansion of these services broadens the geographic reach and hours of operation of these community-based crisis prevention and early intervention services. As a result, more community members are able to receive care and linkage to the appropriate mental health service or other type of community, social, or health service needed at critical times in their lives.

Target Population: The CRP program serves individuals throughout the lifespan who are experiencing a mental health crisis. There is a focus on serving people living with a serious mental illness who are not connected to ongoing mental health services, those who are uninsured, and those recently discharged from an acute psychiatric setting.

I. FY 2018-19 Outcomes:

a. **Number of unique consumers/clients served:** 925
b. **FY 2018/19 Impact:** Here are some examples of the impacts the mobile crisis teams has on individuals, families, and the greater community:
    - A friend of a homeless man living near a storage facility called to request assistance. The individuals had a history of psychiatric hospitalizations in various counties in California but was not connected to care. The mobile crisis team responded to the location and met the friend who had called there. The team coordinated getting this individual to an urgent psychiatric medication clinic where he received medications. He was also connected to ACCESS and referred to a specialty mental health medication clinic for ongoing services.

- The mobile team provided support to a family after they discovered their love one had died by suicide. With permission, staff followed up with the child's school to ensure that the counselors were alerted that the child might need support upon returning to school.
- MET was dispatched to a 911 generated call regarding a person behaving bizarely in the community. Once it was determined that the individual was intoxicated, a detox/sobering center was offered and the person accepted services. The team transported the individual to the most appriate level of care.
- A mother called MCT to evaluate her son who was severely depressed, nearly mute, and had been making suicidal gestures. His mother was very concerned since her son had a serious suicide attempt a few years ago. The team arrived and the son was supported to a psychiatirc hosptial and admitted.

II. Please describe ways that the program strives to:

a. **Reduce mental health stigma:** The mobile crisis teams provide ongoing outreach, engagement, and psychoeducation to individuals living with mental health challenges, their loved ones, law enforcement, and the general community. We highly value ACBH's Office of Consumer Empowerment and strive to incorporate consumers' voices in the planning, delivery and improvement of our services. Our staff attend the Pool of Consumer Champions (POCC) conferences and include individuals with lived experience of mental illness in staff interviews. We incorporate the views and feedback provided by the Office of Family Empowerment and the Office of Ethnic Services in the recruitment, staff retention, training needs, and implementation of the services provided.
b. **Create a welcoming environment:** In an effort to increase contact with those most in need of crisis services, South County CRP transitioned from a traditional outpatient clinic to a fully field based program effective January 2019. Individuals are no longer required to schedule appointments or travel to our clinics. We now provide crisis intervention to individuals across the lifespan experiencing a mental health crisis anywhere in Alameda County and we respond within a few minutes to a few hours of the request for service.

III. Language Capacity for this program: We currently have staff who speak English, Spanish, and Japanese. Staff use the Language Line for all other languages when translation is needed/requested. We will soon add video translation as well. We anticipate this added resource will aid in our efforts to be more inclusive and culturally affirming.

IV. FY 2018-19 Additional Information: In addition to crisis intervention, our field based services include increased outreach and engagement including diversion from emergency departments and other acute settings. We are increasing our referrals to crisis residential treatment programs, detox/sobering centers, a peer respite, and Wellness Centers when appropriate. We are also doubling our efforts to offer and inform the community about voluntary mental health services. In the coming year we are adding new teams including two post crisis follow up teams, an additional mobile crisis team staffed by a clinician and EMT, and a community outreach team focused on engaging individuals with serious mental illness who are homeless. Alameda County has experienced a 47% increase in homelessness since 2017 according to EveryOne Home, the organization that conducted the most recente homeless count. The ongoing services and additional services that will be delievered is expected to connect many of these individuals to supports they need. The CRP staff are key participants in a coordinated homeless outreach campaign throughout Alameda County in cooperation with several other community based service providers.

FY 2019-20 MHSA PLAN UPDATE
COMMUNITY SERVICES & SUPPORTS (CSS) UPDATE REPORT

V. FY 2018/19 Challenges: Our transition to a field-based model resulted in a change in operating hours. Our coverage is 8am-8pm Mon-Fri which better suits the needs of the community. This transition was difficult for staff and resulted in some transfers to other departments. We are in the process of recruiting more staff as well as many other mental health providers in the Bay Area. Housing costs have not only impacted those we serve but also the pool of applicants. Difficulty staffing our teams has impacted the rate of our expansion.

The closure of our outpatient crisis clinic required other parts of our system to quickly address the needs of consumers who require ongoing outpatient services post crisis. CRP staff played a vital role in ensuring consumer needs were met during this transition by assisting with the development of an urgent medication drop-in clinic and training ACCESS staff who assess for levels of care and assign consumers to ongoing services.

Outreach and education to law enforcement about our increased mobile crisis capacity has been challenging since we have historically received referrals primarily from the Oakland Police Department. Now we are available to law enforcement throughout Alameda County (approximately 14 jurisdictions, with Berkeley and Albany excluded). In addition, we have also reached out to many community providers and the general community to encourage referrals to our services.

VI. FY 2019/20 Projections of Clients to be Served: We expect to have a significant increase in our ability to respond to more crisis calls in the community in the next year as we expand the number of mobile crisis staff, the geographic areas served and the hours of operation for the mobile crisis teams. We also expect to increase our ability to link unconnected individuals with serious mental illness who are homeless to services through the new Community Connections program. Lastly individuals who experienced a crisis such as going to John George Crisis Stabilization Unit or being seen by a mobile crisis team will be receiving telephonic or face to face post crisis follow up services within 24-48 hours of the crisis event.

VII. FY 2019-20 Program or Service Changes: As previously mentioned, CRP transitioned to a fully based model via our mobile crisis expansion. We hope to double our staff within the next year, expand our post-crisis follow up teams and community outreach team while also expanding our operating hours to include weekends.

FY 2019-20 MHSA PLAN UPDATE
COMMUNITY SERVICES & SUPPORTS (CSS) UPDATE REPORT

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 7

PROVIDER NAME: Alameda County Behavioral Health

PROGRAM NAME: Behavioral Health Court (BHC)

Program Description: Alameda County Behavioral Health Court is a 12-24 month program of court oversight and community treatment for persons experiencing severe mental illness whose qualifying crimes result from their illnesses. The goals of BHC are to reduce recidivism and improve the quality of life, and assist severely mentally ill offenders by diverting them away from the criminal justice system and into community treatment with judicial oversight.

Target Population: Justice involved adults age 18 and older with serious mental illness and co-occurring substance use disorder. Individuals must have pending criminal charges that were the result of their symptoms of mental illness. Consumers include Transitional Age Youth, Adults and Older Adults.

I. FY 2018-19 Outcomes:

a. **Number of unique consumers/clients served:** Approximately 226 clients were assessed for Behavioral Health Court, and if qualified and agreeable were connected to specialty mental health treatment. At close of FY2019, there were approximately 104 clients who additionally met the criteria and were actively admitted into Behavioral Health Court. Approximately, 24 individuals “graduated” from Behavioral Health Court last year, and had their criminal charges reduced, dismissed, or probation removed or resumed.
b. **FY 2018-19 Impact:** As a result of Behavioral Health Court, clients were able to have improved access to treatment, increased engagement with wellness and recovery activities, and reduced number of days in institutional settings. The BHC program also improves public safety, health, and property of the surrounding community.

II. Please describe ways that the program strives to:

a. **Reduce mental health stigma:** BHC reduces stigma by reminding clients and the community that hope and recovery are possible. By having regular engagement with treatment and ongoing court oversight, clients are able to maintain stability in the community and make progress toward recovery in discovering meaningful activities and holding meaningful roles, often returning to school or work and becoming leaders and role models for their peers newly enrolled in Behavioral Health Court.
b. **Create a welcoming environment:** BHC is a collaborative effort between the Alameda County Superior Court, District Attorney, Public Defender, Alameda County Behavioral Health, and community mental health treatment providers. The BHC Team consists of dedicated staff from each department who have special knowledge and sensitivity to mental health issues, in addition to representatives from forensic focused treatment teams. BHC is non-adversarial. BHC Team members realize the importance of recognizing and rewarding individuals who do well. Participants are praised and rewarded in court for their progress.

III. Language Capacity for this program: The BHC program is able to utilize ACBH Language Phone Line and in person Language Interpretation Services that are available to the court. The courts’ Language

Services are able to accommodate almost any language needed including sign language. BHC is also able to use the language interpretation phone services that are contracted through the county.

IV. FY 2018-19 Additional Information: It is important to note that BHC is partially funded by the Alameda County Behavioral Health through funds made available by the Mental Health Services Act of 2004. ACBH provides the funding for the Clinical and Peer Specialist and Clinical Supervisor. Funds for other court staff are provided by their respective agencies.

V. FY 2018-19 Challenges: The BHC program has gone through changes both in staffing and management. The BHC program was previously embedded within the Adult Forensic Behavioral Health (AFBH) program and is now embedded within the Adult and Older Adult System of Care. This change has overall been positive by providing improved linkage to outpatient services and access to the right-matched level of care needed. BHC continues to make adjustment to work flows related to the transition of all referrals being routed through ACCESS and Centerpoint. ACBH leadership is currently in the process of making interim and provisional staffed positions permanent.

VI. FY 2019-20 Projections of Clients to be Served: Depending on the volume of arrests and charges brought against clients with severe mental illness, BHC will continue to serve as many individuals as possible. There is currently no limit on the number of clients BHC may serve.

VII. FY 2019-20 Program or Service Changes: There have been several new laws implemented in the recent years that affect our community and implementation of services in forensic services. As a result we are actively in the process of revisiting the MOU created with our collaborative court partners, and adjusting the work flow procedures and related policies as needed.

FY 2019-20 MHSA PLAN UPDATE
COMMUNITY SERVICES & SUPPORTS (CSS) UPDATE REPORT

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 7

PROVIDER NAME: Mental Health Court Specialist

PROGRAM NAME: Court Advocacy Project (CAP)

Program Description: CAP increases access to community mental health services and reduces recidivism through advocacy and release planning for the following services: 1. Identify and connect defendants with a mental illness to treatment services while in jail and refer to community treatment for post release follow up; 2. Involve community treatment providers in the court process for their clients and notify them of court status to ensure continuity of care; 3. Assist Judges, Public Defenders, District Attorneys & Probation in understanding mental illness and treatment resources; 4. Identify underlying issues leading to recidivism; i.e. Housing, Benefits, Medical Issues, Substance Abuse, etc.; 5. Advocate for specialty mental health treatment, such as hospitalizations for acutely ill, suicidal, and gravely disabled individuals; 6. Assist family members in navigating the courts and the mental health system of care.

Target Population: Justice involved adults age 18 and older with serious mental illness and co-occurring substance use disorder. Consumers include Transitional Age Youth, Adults and Older Adults.

I. FY 2018-19 Outcomes:

a. **Number of unique consumers/clients served:** CAP served 57 individuals directly by offering mental health services as an alternative to incarceration. This included developing community re-entry plans for clients who were in-custody initially on felony or felony probation charges. As a result, clients spent fewer days in jail and more time connected to community treatment.

   CAP also served approximately 25 individuals who were charged with misdemeanors, but were considered incompetent to stand trial. Once someone is found incompetent on a misdemeanor charge, CAP will craft a mental health treatment plan for these clients so that they may engage in treatment, and remain out of custody as they make progress towards competency.

   CAP had approximately 200 contacts offering consultation and education to Judges, Public Defenders, District Attorneys, Probation Officers, community treatment providers, and family members. As a result, Criminal Justice Professionals were better able to recognize, understand, and address the underlying issues leading to recidivism; families and community treatment providers were better able to navigate the court system and advocate for their loved ones/partners, and clients were linked to the right-matched level of behavioral health care support.

   <u>Case Example for CAP</u>: "John" is a 24 year old African-American Transition Age Youth. John has suffered multiple traumas in his short life. His mother died of cancer when John was 12. His father struggled with an addiction to heroin and he went to prison when John was 15 years old. John was able to identify only one remaining main support. He was referred to CAP through his Public Defender after being arrested and charged with multiple attempted car burglaries. John was homeless and he broke in cars to get some sleep or take items that would get him money to survive. John experienced severe depression with psychosis. CAP assessed him and advocated

for him to be connected with a Full Service Partnership through the Fred Finch STAY program. It took some negotiation with the District Attorney, who initially didn't want to grant a re-entry plan for client, because he felt John had multiple offenses, and was a potential danger to the community. In response to this concern, CAP was able to refer John to Jay Mahler Recovery Center as an initial transition place after incarceration. The STAY Program was able to engage with him more there and assisted him in his transition to live with a friend. John was able to also re-connect with his brother. John continues to work with the STAY Program. STAY was able to secure housing for him, help him to manage his mental health symptoms, and as a result he has not returned to jail. While he initially had follow up court dates to provide progress reports from his treatment team, he was eventually placed back on probation with no further court dates. John has not returned to jail since his involvement with the Court Advocacy Project, and continues to thrive in his recovery with the STAY Program.

b. FY 2018-19 Impact: Overall, CAP reduces recidivism back to jail by connecting people with serious mental health issues to outpatient mental health services; and crafting mental health dispositions for re-entry back into the community.
As a result of CAP services:
- Clients spent fewer days in jail and more time connected to community treatment at the right-matched level of behavioral health care support
- Criminal Justice Professionals were better able to recognize, understand, and address the underlying issues leading to recidivism
- Families and community treatment providers were better able to navigate the court system and advocate for their loved ones/partners, and clients were linked to

II. Please describe ways that the program strives to:

a. Reduce mental health stigma: CAP works to reduce stigma by educating criminal justice professionals in the court system about clients with mental health issues and how to refer or connect people with mental health treatment. This includes educating court staff about language that is prejudiced, treating people as people not as a diagnosis, and utilizing person first language amongst the entities in the court.
CAP works to address clients' internalized stigma by being respectful of individual or family differences, and following the professional ethical code of conduct: 'Social workers respect the inherent dignity and worth of the person. Social Workers treat each person in caring and respectful fashion, mindful of individual differences and cultural and ethnic diversity. Many of our clients have multiple cultural histories, having mental health issues is another to add to that cultural history.'

b. Create a welcoming environment: CAP believes it's our responsibility as clinicians to create a safe and tolerant environment, whether seeing a client at the jail, or in the court. CAP strives to be free from prejudice, stigma, and discrimination, to be respectful, understanding, and trauma-informed. CAP focuses on the ethical practices of social work as mentioned above.

III. Language Capacity for this program: The CAP program is able to utilize ACBH Language Phone Line and in person Language Interpretation Services that are available to the court. The courts' Language Services are able to accommodate almost any language needed including sign language. CAP is also able to use the language interpretation phone services that are contracted through the county.

FY 2019-20 MHSA PLAN UPDATE
COMMUNITY SERVICES & SUPPORTS (CSS) UPDATE REPORT

IV. FY 2018-19 Additional Information: In early 2019, CAP took a pause on accepting any new referrals to both focus on managing some particularly challenging client transitions, focus on revising educational materials and adjusting to system wide changes. This included connecing with key stakeholders at the Public Defender's Office, the District Attorney's Office, the Superior Courts, and the Family Education and Resource Center for input and collaboration on how to improve CAP services and linkage to supports for our mutual clients. The CAP program designed a plan for stepped phases of educating stakeholders, providing opportunities for education on a larger system scale, and began accepting new referrals again just before the start of FY2019/20.

V. FY 2018-19 Challenges: The CAP program has gone through change both in staffing and management. The CAP program was previously embedded within the Adult Forensic Behavioral Health (AFBH) program and is now embedded within the Adult and Older Adult System of Care. This change has overall been positive by providing improved linkage to outpatient services and access to the right-matched level of care needed. CAP has struggled with the transition of leadership and changing staff. ACBH leadership is currently in the process of making the interim supervisor position permanent.

VI. FY 2019-20 Projections of Clients to be Served: Depending on the volume of arrests and charges brought against clients with severe mental illness, CAP will continue to serve as many individuals as possible. There is currently no limit on the number of clients CAP may serve.

VII. FY 2019-20 Program or Service Changes: CAP clinicians were initially designated to sit in high traffic criminal court rooms identified by the Presiding Criminal Court Judge in hopes of identifying clients/defendants with severe mental illness who might otherwise slip through the cracks and to assure timely access and linkage to mental health services, improving the ability of the criminal justice system to craft appropriate treatment-based options in the community.

After communications with community stakeholders this past year, CAP has 2 full time clinicians who plan to regularly attend court at:

- Rene C. Davidson Courthouse, Department 11
- East County Hall of Justice, Department 705
- Wiley W. Manual Courthouse, Department 107
- Fremont Hall of Justice, Department 605

CAP Clinicians may also attend other departments at the following courts on a case by case basis at the following:

- East County Hall of Justice
- Rene C. Davidson Courthouse
- Fremont Hall of Justice
- Hayward Hall of Justice
- Wiley W Manual Courthouse

FY 2019-20 MHSA PLAN UPDATE
COMMUNITY SERVICES & SUPPORTS (CSS) UPDATE REPORT

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 8

PROVIDER NAME: Alameda County Behavioral Health

PROGRAM NAME: Juvenile Justice Transformation of the Guidance Clinic

Program Description: Provides in-depth assessment and treatment for youth in the juvenile justice system. Coordinates referrals and linkages to mental health services in order to ensure seamless continuity of care when discharged from juvenile hall to community based providers.

Target Population: Youth ages 12-18 years old who are involved in the juvenile justice system and their families.

I. FY 2018-19 Outcomes:

a. **Number of unique consumers/clients served:** 576 clients served
b. **FY 2018-19 Impact:**
    - Youth entering the Juvenile Justice Center were assessed by a Guidance Clinic clinician and provided the opportunity for ongoing therapeutic support.
    - Youth in the Juvenile Justice Center were provided crisis support during traumatic/triggering events associated with being detained.
    - Upon release from the Juvenile Justice Center, the mental health needs of youth were assessed (using records from Clinician's Gateway and recommendations from Guidance Clinic clinicians), and youth and families were referred to appropriate care, e.g., therapy, psychiatry, etc. A total of 513 youth were seen by a GC staff person in the Transition Center.

Case study/client-family story:

A young man, BT[1], was detained at the Juvenile Justice Center (JJC) earlier this year. It was the first time BT had every been detained. During his detention, BT was assessed by a Guidance Clinic (GC) crisis clinician after a referral from the JJC medical clinic. BT disclosed to the GC crisis clinician that he had attempted suicide several times in the past. While the GC crisis clinician determined that BT was not actviley suicidal, she did feel that BT would benefit from regular mental health services, which he had not recieved in the past. The GC crisis clinician referred BT for a medication evaluation, referred BT to the unit clinician for ongoing therapy, and helped BT create a saftey plan that identified specific goals, triggers, and coping strategies that BT could use to address any suicidal feelings while BT was in detention. The GC crisis clinician also worked with Probation staff in the JJC to establish a saftey protocol to monitor BT.

While detained in the JJC, BT was connected to regular mental health services for the first time. He starting recieving intensive services from the GC unit clinician, who met with BT several times a week. BT was also evaluated by a GC psychiatrist who started BT on medication to address his deperession and sucidal thoughts.

The GC mental health team also worked with BT's Probation Officer to connect with BT's father. The GC team discussed BT's needs with BT's father and highlighted the importance of regular mental health

[1] Not real initials.

services. BT's father was in agreement with the plans established by the GC team and understood the need for ongoing servcies once BT was released.

Before BT's release, the GC staff person in the JJC Transition Center created a discharge plan with BT's father including referral to services in the community. Upon release, BT was given a persrciption for medication and an appoitment was made with a mental health provider in the community. BT and father were extrmley grateful for the support of the GC team. BT has been maintaing safely in the community for several months.

II. Please describe ways that the program strives to:

a. **Reduce mental health stigma:**
   GC clinicians meet with the majority of youth who are detained at the JJC.[2] An important role of the GC clinicians, is to validate that detention can be very traumatic and triggering experience for our youth, and that often times it helps to have someone to talk to and to process various feelings. In doing so, the GC clinicians help youth understand how mental health services can be beneficial and supportive during stressful times, thereby reducing any stigma that may be associate

   Additionally, because GC clinicians are assigned to the JJC living units (where youth are housed), they interact with youth on a regular basis. They develop strong relationships and good rapport with youth. Youth begin to see GC clinicians as trusted adults who they can turn to when they are feeling angry, sad, stressed, or alone.

   Finally, since multiple youth on the living unit access mental health services from a GC clinician, the services become normalized. Our youth often share that they feel most comfortable accessing mental health services from the GC clinicians.

b. **Create a welcoming environment:**
   As noted above, GC clinicians are trained to quickly develop strong trusting relationships with our youth and work hard to build rapport. GC clinicians achieve these goals by using techniques such as active listening, motivational interviewing, and creating safe-spaces for youth to discuss sensitive topics. The FC clinicians' offices are welcoming spaces where youth are allowed to be vulnerable and where youth turn in times of crisis.

   GC clinicians also help youth reconnect with families. GC clinicians work with youth to in family therapy sessions or help youth engage with family members over the phone in order to maintain or re-establish family supports. These services are critical in such a stressful environment, and help youth and their families feel more welcomed and connected.

III. Language Capacity for this program: Current language capacity includes: Cantonese, Spanish, and Vietnamese.

IV. FY 2018-19 Additional Information: The average daliy census of youth in detention continues to decline. We have experienced this trend for several years. However, while the number of youth in

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[2] Occasionally, youth are booked-in and quickly released from the JJC. These youth are not detained long enough to meet with a Guidance Clinic clinician.

detention continues to decline, the mental health needs of many youth in detention have increased. GC clinicians often spen a lot of time providing services to individual youth who need intensive services.

V. FY 2018-19 Challenges: Staffing was a major challenge for the GC and our services this year.

- One GC clinian accepted a position at another Alameda County Behavioral Health (ACBH) clinic. We are currently unable to hire behind that position, but are hopeful we will be able to do so in the near future.
- A new position, a Mental Health Specialist (MHS) III, was created to staff the JJC Transition Center, taking over for a beahvioral health clinicin who was re-assigned to a new Transition Age Youth Unit. The MHS III position was difficult to fill and remained vacant several months. Luckily we were able to fill the position in April.
- The GC Manager, who worked for ACBH and in the Juvenile Hall for over 30 years, retired in May of this year. This was a major loss for the GC as the manager had years of system experience and knowledge. This also resulted in the GC manager position being vacant for the last two months of the fiscal year. However, a new manager has been hired and will be on board in August.

VI. FY 2019-20 Projections of Clients to be Served: 500 clients

VII. FY 2019-20 Program or Service Changes: A new unit designed for Transition Age youth has been created and is expected to be open and occupied next FY. This will result in an older population of youth (21-24 years old) being served in the JJC.

FY 2019-20 MHSA PLAN UPDATE
COMMUNITY SERVICES & SUPPORTS (CSS) UPDATE REPORT

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 9

PROVIDER NAME: Seneca Family of Agencies

PROGRAM NAME: Multi-Systemic Therapy (MST)

Program Description: Multi-Systemic Therapy (MST) is a unique, goal-oriented, comprehensive treatment program designed to serve multi-problem youth in their community. MST interventions focus on key aspects of these areas in each youth's life. All interventions are designed in full collaboration with family members and key figures in each system- parents or legal guardians, school teachers and principals, etc. MST services are provided in the home, school, neighborhood and community by therapists fully trained in MST. Therapists work in teams and provide coverage for each other's caseloads when they are on vacation or on-call. MST therapists are available 24 hours a day, seven days a week through an on-call system (all MST therapists are required to be on-call on a rotating schedule). Treatment averages 3-5 months.

Target Population: Youth (ages 0-21) referred who are on probation in Alameda County and are at risk of out of home placement due to referral behavior and living at home with a parent or caretaker.

I. FY 2018-19 Outcomes:

a. **Number of unique consumers/clients served:** 52
b. **FY 2018-19 Impact:** AA came to the attention of the MST program through a weekly meeting in which youth are considered for out of home placement. When the MST program was recommended to AA’s mother, she stated that she would “do whatever it takes” to keep her son at home.

   MST treatment focused on both tightening supervision and monitoring of AA, strengthening the home to school link between AA’s mother and his school, and strengthening the communication between AA and his family. MST clinician utilized rapport building and engagement techniques to build a therapeutic alliance and trust between AA, his family, and MST clinician. MST clinician also collaborated with AA’s natural support network such as other family members and supportive school personnel, ensuring that AA’s mother was able to build and sustain the support received from all.

   Through joint efforts between AA’s individual drive, his mother’s commitment to doing whatever it takes, and MST clinician’s continuous efforts, AA completed all of his terms of probation after only being on probation for two months. With consult from MST clinician, he attended his next court hearing with letters of support and evidence of completion of his requirements in hopes of getting dismissed from probation, but both he and his family were dismayed that he was not dismissed from probation.

   AA and his family, though discouraged, remained hopeful and demonstrated continuous effort to maintain his areas of progress. AA continued participating with MST therapy, completed extra hours of community service hours, graduated high school, and again obtained letters of support to advocate for his dismissal at his next court date. MST clinician provided services aimed at family continuing to sustain advances made and to ensure that Freddy maintained progress. In addition, MST clinician utilized advocacy techniques with AA’s probation officer to

ensure that all work together so that she may recommend his dismissal, adding more power to his chances of being dismissed at only 4 months of being on probation.

AA attended his next court hearing and was released from the Juvenile Justice System after being on probation for 4 months, often unheard of in a system which keeps youth on probation for much longer periods.

In addition to being dismissed from probation, AA graduated high school, was accepted into a career related internship program to begin in the summer, was working full time, and he was receiving interview opportunities for other positions related to his career goals. All was made possible through continuous efforts made by him, his family, his school supports, and the MST team.

II. Please describe ways that the program strives to:

a. **Reduce mental health stigma:** Many of the families we provide services to have experienced multiple traumas and have Family members who have mental health issues that have impaired their ability to successfully function in the community. MST provides in home and community-based service which reduces the stigma many families feel related to being in a facility that provides mental health services. By providing services in the home and community, MST strives to remove this stigma. MST is also present-focused and strength-based which empowers the families to utilize the positive aspects of their family system to develop effective strategies and interventions that support and assist them with managing any mental health issues they are encountering. The goal is to provide an experience with the client and the family that will disconfirm their negative beliefs about mental health treatment and the stigma that’s often attached to it.
b. **Create a welcoming environment:** One of the primary tenants of MST is engagement. Family and caregiver engagement is critical to ensure positive treatment outcomes. The other purpose of engagement is to ensure that the family feels heard and understood; we achieve engagement by spending a great deal of time listening to the “story” of the family. This creates an environment of acceptance and understanding which leads to higher level of engagement between the clinician, the client and their family.

III. Language Capacity for this program: English and Spanish

IV. FY 2018-19 Additional Information: None

V. FY 2018-19 Challenges: MST receives referrals from the Alameda Co. Juvenile Probation Department. There are fewer and fewer youth on formal probation which has reduced the number of referrals received this year. Additionally, the cost of licensing and consultation fees associated with this evidenced based practice are very high which makes fiscal sustainability of this program challenging.

VI. FY 2019-20 Projections of Clients to be Served: 20 to 30

VII. FY 2019-20 Program or Service Changes: None

FY 2019-20 MHSA PLAN UPDATE
COMMUNITY SERVICES & SUPPORTS (CSS) UPDATE REPORT

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 11

PROVIDER NAME: Seneca Family of Agencies

PROGRAM NAME: Crisis Stabilization Unit (CSU): Willow Rock

Program Description: The Willow Rock Crisis Stabilization Unit (CSU) is an unlocked, specialty mental health program for medically stable youth ages 12 to 17 years. The CSU also functions as the Alameda County Receiving Center (Welfare and Institutions Code 5151) for youth who are placed on a WIC 5150/5585 civil commitment hold in Alameda County. All youth arriving at the Willow Rock Crisis Stabilization Unit receive a physical health and a mental health assessment, and are provided ongoing assessment, crisis intervention and crisis stabilization services prior to discharge to the community or transfer to an inpatient psychiatric facility.

Target Population: The Willow Rock CSU serves medically stable youth ages 12 to 17 years experiencing a mental health crisis. The program may serve up to a maximum of ten clients at a time. Youth may arrive on a WIC 5585 civil commitment hold or as a voluntary "walk-up" from the community.

I. FY 2018-19 Outcomes:

a. **Number of unique consumers/clients served:** 985 unique clients, 1165 admissions
b. **FY 2018/19 Impact:** 41% of CSU clients were diverted from inpatient hospitalization. The remaining 59% were referred to the appropriate level of care to continue receiving necessary treatment.

II. Please describe ways that the program strives to:

a. **Reduce mental health stigma:** The CSU provides 24-hour crisis stabilization services to youth 12-17 that are free and open to the public. We actively work to reduce mental health stigma by welcoming youth and providing them with services based in our values of respect and curiosity, and our agency mission of providing unconditional care. Whether youth seek our services voluntarily or via civil commitment hold, our goal is to make youth and caregivers as comfortable with our process as possible through validation, active listening, and clear communication about each step of the process. We reach out to caregivers to keep them informed of information and provide psycho-education and support as their child navigates our process. If a youth is meeting criteria for inpatient hospitalization, we take the time to explain to the youth and their caregivers what this process will entail and make space for their questions and concerns. During our aftercare meetings with youth who are being discharged home, we help youth and caregivers develop a better understanding of the elements that led to the crisis and provide them with alternative ways to cope together in the future that are client-driven. We also provide youth and families with referrals and resources to continue their journey seeking services.
b. **Create a welcoming environment:** Providing a welcoming environment is important to us from the comfortable furniture and homelike décor we have, to the care and warmth our staff provide youth and families from the moment they enter our doors. We meet the youth where they are, providing them with the services that will offer them the best opportunity to take the first steps towards recovery from crisis. This includes the simple things like a shower, food and water, or rest, and more complex interventions involving activities and counseling

conversations, all while completing our multi-disciplinary assessment process. We are committed to cultural humility and a strengths-based approach to working with youth and families. When asked to rate our staff members on how professional and friendly they were when working with our youth and families, youth rated our staff at an average of 3.62/4 and caregivers rated our staff at an average of 3.96/4 for the FY2018-2019 (1= Strongly Negative, 2=Negative, 3= Positive, 4=Strongly Positive).

III. Language Capacity for this program: English, Spanish, Vietnamese. Additional language services provided through contracted interpreters.

IV. FY 2018-19 Additional Information: None

V. FY2018/19 Challenges: We have experienced challenges this year securing interfacility transport for youth who are meeting criteria for inpatient hospitalization and accepted at hospitals in the greater Bay Area, especially when those hospitals are out of county. Inpatient beds for adolescents are limited and during high volume periods, youth may receive acceptance at a hospital out of county but have difficulty getting there due to transportation limitations presented by the distance, the youth's specific insurance coverage, and how the ambulance companies serving the area work with those insurance companies and county insurance providers. We are invested in working with our county partners, the ambulance companies, and other important stakeholders to help resolve this issue to the best of our ability in 2019-2020.

VI. FY 2019/20 Projections of Clients to be Served: 1,000 - 1,200

VII. FY2019-20 Program or Service Changes: None

A. COMMUNITY SERVICES & SUPPORTS (CSS) PROGRAM SUMMARIES

FY 2019-20 MHSA PLAN UPDATE
COMMUNITY SERVICES & SUPPORTS (CSS) UPDATE REPORT

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 14

PROVIDER NAME: Asian Health Services Specialty Menth Health (SMH)

PROGRAM NAME: Language ACCESS Asian

Program Description: Language ACCESS Asian Program operates a designated Intake and Referral line, screens and evaluates medical necessity, and determines appropriate service levels for community members requesting mental health services. In various standing community meetings and ad-hoc events, outreach and psychoeducation are provided to raise awareness/knowledge of mental health and help-seeking amongst API communites. When appropriate, home-based and hospital-based visits are conducted to enhance clients' engagement and service participation. The Program also provides short-term crisis stabilization outpatient treatment and reduces utilization of higher levels of care via medication support, individual therapy, individual rehabilitation, group rehabilitation, collateral, and case management services.

Target Population: Language ACCESS Asian provides mental health outreach, screening, linkage, and treatment serices to all consumers living Alameda County, with primary focus on individuals and families who identify themselves as Asian/Pacific Islanders. The consumers can range in age from Children/Youth (0-15), TAY (16-25), Adults (26-59) to Older Adults (60+).

I. FY 2018-19 Outcomes:

a. **Number of unique consumers/clients served:** Answered inquiries from 506 unduplicated intake clients with more than 1900 services/contacts, connected with appropriate level of services, conducted safety planning for S/I and H/I. Among these clients, 170 clients were fully screened/referred (111 referrals to internal treatment programs, 16 referrals to internal Prevention program, 13 referrals to external treatment programs, 30 referrals to MH services by primary health care).

   Served 108 clients under ACCESS Treatment with assessment, treatment planning, medication support, individual therapy/rehab, group rehab, collateral, and case management services.

   Strategized our outreach initiatives to successfully reach out 1,263 community members in various natures of cultural events, community meetings, and health care settings.

b. **2018-19 Impact:** Increased multiple/easy accesses to MH services and leverage Asian holistic health concept by providing ACCESS consultation, screening, & service referral/assignment at Asian-focused health care clinics (e.g. Conducted a pilot run at AHS Dental Clinic, etc.).

   Conducted outreach to raise MH awareness and introduce MH services amongst the population in Asian-focused street/health fairs and cultural events (e.g. Laney College Under-sheltered Student Resource Fair, San Leandro Lunar New Year Celebration, Khmer Community of Oakland New Year Celebration, St. Mary's Garden Senor Home Annual Health Fair, etc.).

   Provided full support to Asian-focused service organizations to raise MH awareness amongst the population (e.g. Participated in event promotion, film panel discussion, and on-site crisis intervention for "The First Chinese American Mental Awareness Day" organized by Mental

Health Association for Chinese Communities; tailored audience-targeting education material and conducted a workshop organized by Helping Hands East Bay; etc.).

Tapped into standing community meetings to mobilize active community leaders and members through their networking on raising MH awareness and promoting help seeking behaviors amongst API communities (e.g. Participated in Project by Project Community Panel on Homelessness; Attended Asian Advisory Committee on Crime Neighborhood Meeting, etc.).

Initiated the planning with Oakland Asian Cultural Center to host audience targeting seminars and workshops for community members and MH service providers (e.g. "Traditional Chinese Medicine and Modern Medicine Perspectives on Mental Health" in July, "Immigrant Families Challenges and Outlook" in October", etc.).

Client's Story: "Ms. L is a 47 year old Vietnamese woman who immigrated from Vietnam to join her husband in 2017 and fled from the abusive marital relationship in 2018. She suffered from cultural adjustment issues, symptom of depression and trauma, and suicidal ideation leading to an overnight stay at JGP. When she was referred to ACCESS Asian Intake Services, she presented as defensive, concerned, frightened about her situation and was resistant to services due to the stigma of mental health in Vietnamese culture. Through the outreach and rapport building from bilingual and bicultural Vietnamese speaking clinician with ACCESS Asian, she eventually became open to go through screening and receive services. However, client's insurance and unclear document status complicated service arrangement. It required the collaboration between CRP's supervisor and ACCESS Asian supervisor to coordinate care for client given her safety risks and immediate mental health needs before the case was successfully open under ACCESS Asian Treatment Services. As she continued treatment, she experienced a lot of barriers but she made steady progress. There were times when she disengaged completely or became extremely angry at her case manager and mental health services in general. But she always came back and continued to demonstrate resiliency and courage to move forward. This client continues to experience severe dxs of depression and PTSD but she is less resistant, less frightened, and more aware and knowledgeable of her role an individual seeking help. Her being a treatment client under ACCESS Asian provided her with an opportunity to connect with a bicultural and bilingual clinician, who at the very least, can provided culturally competent services. As she approached the end of treatment under ACCESS Asian, she was aware that her road to recovery might take longer than preferred. However, she stayed connected and engaged and was granted Level 1 services. It was what she gained and benefitted in treatment while in ACCESS Asian that motivated her to continue treatment under Level 1 program. She still has bad days where she is angry at her situation. But what's important is that she continues to strive to get better knowing that she has support."

II. Please describe ways that the program strives to:

a. **Reduce mental health stigma:** Increased multiple/easy accesses to MH services and leverage Asian holistic health concept by providing ACCESS consultation, screening, & service referral/assignment at Asian-focused health care clinics (Conducted a pilot run at AHS Dental Clinic, etc.).

   Fostered new generations to internalize the importance of MH and become effective agents to address shame and stigma amongst their peers (e.g. Collaborated with AHS Youth Program to

conduct a youth focus group for developing promotion materials of "Mental Health Anti Stigma Outreach on Asian American Youths" campaign, arranged psychoeducation sessions for Asian Youth Services Committee, etc.).

Conducted online research to build up API MH social media resource bank (recovery stories, sound tracks, video clips, social media pages, etc.) in order to strategize an effective communication approach and launch a sustainable anti-stigma campaign (not just a blast) through social media in coming months.

b. **Create a welcoming environment:** All ACCESS Intake and Treatment clinicians are bilingual and bicultural staff and most of them have social and cultural experiences from immigration families. They have been equipped to effectively access clients' social and cultural needs and deliver services in clients' spoken languages.

   Flyers and/or brochures are available in certain Asian languages (Chinese, Vietnamese, Khmer, Korean, Filipino, and English) to meet the corresponding language needs in this population.

   Psychoeducation materials and corresponding workshops are conducted by bilingual and bicultural staff in response to clients' needs and service requests from other organizations.

   Home-based and hospital-based visits are conducted to enhance clients' engagement and service participation.

   During ACCESS Intake engagement/screening, Intake clients are provided with community resources for imminent life stressors and/or linked to appropriate agencies/county service teams for engagement/medical issues (e.g. IHOT, Urgent Care Medication Services).

   For clients of ACCESS Treatment service, PCP, board and care home, pharmacy, ACVP, Subpayee Team, HSO, emergency shelter, IHSS, STEPs, AOT, para-transit, and other relevant service agencies are involved in ongoing collaboration to support clients and families.

III. Language Capacity for this program: Services are provided in direct API languages including but not limited to Cantonese, Mandarin, Vietnamese, Khmer, Korean, Japanese, and Mien. For Burmese, Mongolian, and Tagalog speaking clients, services are provided via interpretation.

IV. FY 2018-19 Additional Information: A brief after-call/screening service survey is conducted for ACCESS Intake clients/callers to identify sources of referrals, improve outreach strategy, and fine-tune service quality.

Clients of ACCESS Treatment service, families, and primary caregivers (e.g. board and care home staff) are involved throughout assessment, service plan development, and ongoing service delivery. Closed Case Surveys are completed by clients at the termination of ACCESS Treatment service.

V. FY 2018-19 Challenges: High percentage of referrals were made by PCP and family/friends, the corresponding API clients experienced reluctance and ambivalence to be engaged in help seeking process due to shame & stigma, knowledge gap about MH, and lack of trust in MH providers. In average it took more than 5 services/contacts to complete screening and make appropriate service arrangement. For some clients, screening/services were stiffly declined or it took weeks for the engagement process.

FY 2019-20 MHSA PLAN UPDATE
COMMUNITY SERVICES & SUPPORTS (CSS) UPDATE REPORT

Owing to untimely service seeking, a good number of API clients suffered from S/I, H/I and severe psychiatric symptoms upon the receipt of referrals. It led to difficulties making urgent arrangement of psychiatric services with the limited/allocated resources in a short time frame.

Many clients of immigration families struggled with poverty and lack of transportation/time. It caused difficulties for them to prioritize their MH needs and participate in active treatment even though case management services and transportation assistance were offered.

Some clients were referred by only internal AHS Prevention Program to receive screening and service arrangement. Language ACCESS Asian will initiate collaboration effort with other County Prevention Programs for outreach and linkage services amongst API communities.

There are inadequate bilingual and culturally responsive MH providers for API population. Complications were encountered to refer out mild-moderate clients for appropriate treatment services.

There have been challenges of recruiting bilingual and bicultural qualified staff for unfilled openings in the competition with hospitals, county programs, and other health care settings. The rollout of new outreach activities were delayed and clinician effort/time were thinly spread over all eligible ACCESS Treatment clients.

Owing to the implementation of new EHR system at our agency and transition of staff & graduate interns in the 4th quarter, there were some disruptions of case openings and service delivery under ACCESS Treatment Program. We foresee that new staff and graduate interns will come on board in fall.

VI. FY 2019-20 Projections of Clients to be Served: Outreach and Linkage**:** 1,313 hours of service to 1,875 community members for outreach with the target that screening/linkage will be completed for 600 unduplicated clients amongst them.

Treatment Services - Crisis Response and Stabilization**:** 3,691 hours of service to 130 unduplicated clients, including 322 hours of medication support.

VII. FY 2019-20 Program or Service Changes: ACCESS Asian outreach and linkage services were re-strategized in the 4th quarter and the scope will be further expanded to gear toward the following objectives in the coming fiscal year.

1. Improve API penetration rate by increasing screening and case openings through trust building and multiple/easy access to culturally/linguistically responsive engagement and linkage
    - Mobile/field-based outreach to enhance cultural and linguistic engagement process
    - Pre-treatment case management to help clients address life stressors, remove help-seeking barriers, and prioritize mental health needs
    - Onsite ACCESS consultation, screening, & service referral/assignment to leverage Asian holistic health concept at Asian-focused health clinics, and engage children, youth, TAY, and families at schools and churches
    - Telepsychiatry for early access to psychiatrist to improve engagement and treatment participation through cultural respect for medical doctors
    - Transportation assistance to address transportation mobility issues, social isolation, and limitations of MH services in some areas

2. Promote API help-seeking through audience targeting outreach/psychoeducation at Asian-focused cultural events, community meetings, and a planned wellness resource center
   - Outreach at Asian-focused cultural events and community activities to address cultural barriers and promote help-seeking
   - Audience targeting psyschoeducation at Asian-focused CBO's and community meetings of all natures to reach out active community leaders and members
   - Non-stigmatizing educational materials, seminars, and workshops at a planned Wellness Resource Center to reach out community members
3. Address stigma, shame, & denial of mental illness to raise the awareness/acceptance of mental health among API communities through social/traditional media
   - Anti-stigma campaign materials (recovery stories, sound tracks, video clips, social media pages, etc.) on social media and podcasts
   - PSA on Asian-focused radio/TV channels
   - Asian public figures, celebrities, entertainers to be MH ambassadors for PSA production

A. COMMUNITY SERVICES & SUPPORTS (CSS) PROGRAM SUMMARIES

FY 2019-20 MHSA PLAN UPDATE

COMMUNITY SERVICES & SUPPORTS (CSS) UPDATE REPORT

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 15

PROVIDER NAME: La Clinica

PROGRAM NAME: ACCESS Staffing to Latino Population

Program Description: ACCESS Staffing to the Latino Population program operates a designated intake and referral phone line to screen and evaluate callers for medical necessity and determine appropriate service levels for community members requesting mental health services. ACCESS through La Clinica also provides short-term crisis stabilization outpatient services for clients in crisis to reduce utilization of higher levels of care.

Target Population: ACCESS Staffing to the Latino Population receives call from consumers and family members of consumers of mental health services who identify as Latino living in Alameda County. The consumers can range in age from children (age 0-15) to older adult (60+). The ACCESS line provides Spanish language speaking/culture mental health screenings to get clients connected with appropriate level of services, and obtaining related information for their medical record.

I. FY 2018-19 Outcomes:

a. **Number of unique consumers/clients served:** 680
b. **FY 2018-19 Impact:** 3919 clients were served in FY 18-19. The impact of La Clínica's ACCESS program is that Casa del Sol provides primary linguistic and cultural services for the priority population. La Clinica has a reputation for meeting the needs of Latinos in Alameda County and clients are familiar and comfortable coming to Casa del Sol for services. The current political situation impacts the community and may increase mental health distress which gives La Clinica the opportunity to address their mental health needs as they become emergent. La Clinica is geographically close to eight elementary schools and make an impact on school aged children by providing services that are easily acccessible. Furthermore, La Clinica continues to make an impact by increasing coordiation with primary care to identify clients who would best be served in the specialty mental health setting.

   One example is in the following success story. La Clinica provided services to a transitional aged Latina who was bilingual in English and Spanish. She had severe major depressive disorder and history of cutting and suicidal thoughts. She was abused as child but had never disclosed prior to seeing the therapist at Casa del Sol. The therapist developed a trusting relationship with her and worked to help her process the abuse. The therapist then supported her as she disclosed the abuse to her parents who she feared would be angry and to her brother as he had also experienced abuse from same perpetrator. She was also started on medication as part of her treatment. The disclosure to her family as well as medication improved her symptoms tremendously and she was able to be discharged from care. The therapist supported the client in her educational and personal goals during treatment and by the time she left services, she was able to get an administrative assistant certificate and was creating an Instagram page to share with other teens about her trauma and mental health conditions. The therapist received email a few months later as the client had been contacted by a company called "Why Do We Keep Quiet" who asked her to become an ambassador due to her Instagram page. The client

credited the work she did with the therapist for this opportunity and mentioned that her previous attempts at therapy had been unsuccessful.

II. Please describe ways that the program strives to:

a. **Reduce mental health stigma:** Clinicians normalize the experience of mental health distress and use non-stigmatizing language in both English and Spanish when discussing mental health concerns. All clients are made to feel welcome when entering the building. All Casa del Sol creates an environment where there is an openness to talk about stigma and behavioral health needs as part of overall wellness. La Clinica also provides services through a strengths based, recovery and resiliency lens.
b. **Create a welcoming environment:** Staff greet and serve clients in their preferred language and provide services that are reflective of cultural humility. La Clinica strives to have all of the décor and aesthetic reflect the priority population, and its community. Clients always have the option to include family and/or essential supports in their treatment appointments. La Clinica always provides written materials in the client's preferred language. Furthermore, La Clinica offers a welcoming environment by including toys and videos in the waiting room. La Clinica also has water available for clients. Clients have access to and are encouraged to seek support via Cultura y Bienestar and the traditional healing practices available there.

III. Language Capacity for this program: La Clinica provides services in English or Spanish, depending on client preference. All clinicians, psychiatry staff and front desk staff are bilingual in English and Spanish. All written material is available in English and Spanish.

IV. FY 2018-19 Additional Information: None

V. FY 2018-19 Challenges: La Clínica does not have an electronic health record (EHR) that would allow us to capture the requested patient data necessary for county reports. However, this data is entered into INSYST at the time of registration, but not available at the client level. In addition, successful linkage to lower levels of care is inconsistent because a clearinghouse or updated database of these providers does not exist. Medicare-Medi-Cal recipients also comment on increased challenges with seeking mental health services as they often do not understand that when selecting their health plans, they are also selecting mental health providers. The absence of emergency psychiatric medication centers continues to place an increased burden on CBOs to provide these services. Additionally, there is a lack of policy and protocol clarity around patients discharging from subacute care back into the community centers.

Changing documentation standards and service delivery without a final contract in the last quarter of the year make it difficult to meet deliverables. Additionally, although the system change that made ACCESS the gatekeepers the services may be beneficial in the future, the current rollout has been challenging. This involves retraining staff to master an already complicated referral process. There has been a lack of clarity around the NACT rules that make compliance difficult when the standards are not clearly defined.

It is a challenge to have the same ANSA rules for ACCESS clients because they are inherently stabilization services and ANSA is meant to offer an enhanced view of assessment. QA has led us to understand that ANSA is being used as an outcome measure. This invalidates the clinical data collected by the ANSA. ANSA use was validated for highlighting additional area of need and focus.

FY 2019-20 MHSA PLAN UPDATE
COMMUNITY SERVICES & SUPPORTS (CSS) UPDATE REPORT

We have observed an increase in Mam speakers or use a subtle dialect that is hard to translate which are not reflected in the language lines.

VI. FY 2019-20 Projections of Clients to be Served: 550

VII. FY2019-20 Program or Service Changes: La Clinica is moving to an electronic health record in April 2020.

FY 2019-20 MHSA PLAN UPDATE
COMMUNITY SERVICES & SUPPORTS (CSS) UPDATE REPORT

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 17

PROVIDER NAME: Horizon Services, Inc.

PROGRAM NAME: Residential Treatment for Co-Occurring Disorders- Cronin House

Program Description: Cronin House is a short-term, all-gender inclusive residential treatment facility for adults with co-occurring diagnoses (substance use and mental health) that serves clients for up to 90 days. The program is licensed for 34 beds and currently provides a variety of clinical services, including individual therapy, group therapy, independent living skills development, and additional skill building to support treatment and recovery. The program provides a day-rehabilitation model in the mornings, which includes 3 consecutive hours of group therapy with specific topics to address mental health needs. Furthermore, there are substance-use focused groups provided during residential programming in the afternoons and evenings. Additional services include crisis intervention/stabilization support, case management, assessment, and treatment planning. They utilize a variety of therapeutic interventions, and particularly specialize in the use of DBT, CBT, Brief Therapy, and Motivational Interviewing.

Target Population: All-gender inclusive and serves adults (ages 18-59) with a co-occurring diagnosis.

I. FY 2018-19 Outcomes:

a. **Number of unique consumers/clients served:** 218
b. **FY 2018-19 Impact: Case Study Below –** One of our clients was a trans-identifying (female to male) client who came to us with a documented diagnosis of PTSD and Schizoaffective, and multi-substance use including Methamphetamine. His psychiatrist was claiming the client had dissociative identity disorder. In our observations, this client had a very confrontational relationship with his step-mother, and his biological father was very passive/permissive. None of his family members were accepting of his identity. Through various observations and interventions, we were able to determine that this client's appropriate diagnosis was PTSD and that the other symptoms were primarily due to defense mechanisms, flashbacks, and substance use, rather than schizoaffective or DID diagnosis. After determining the appropriate diagnosis and needs of the client, he was able to have a positive transition to his next placement to receive the necessary care and treatment. It was the first time he had ever completed a treatment program successfully.

II. Please describe ways that the program strives to:

a. **Reduce mental health stigma:** We support clients in a client-centered way and believe that it is the responsibility of the program to support the client in his/her needs, rather than fit the client into our specific treatment approach. We utilize individual behavior support plans and intervention plans for the clients with particularly specialized needs.
b. **Create a welcoming environment:** All of our staff greet new clients constantly, even as the client is waiting in the lobby area for the intake appointment. We also provide individualized care and occasionally conduct room changes or specialized interventions/groups based upon the needs of our clients. Many of our staff and managers have an "open door policy" and work directly with clients throughout the day/week to ensure the needs are being met and clients are feeling heard/supported.

FY 2019-20 MHSA PLAN UPDATE
COMMUNITY SERVICES & SUPPORTS (CSS) UPDATE REPORT

III. Language Capacity for this program: English, Hindi, Tagolog, Cantonese, Spanish (to some capacity). The other languages can be utilized through translation services.

IV. FY 2018-19 Additional Information: None

V. FY 2018-19 Challenges: We continue to struggle to maintain a full census and keep up with documentation requirements due to staffing needs. We do not seem to have enough clinical staff members to keep high-quality charts maintained/updated and also provide the highest quality services to the clients directly. We see many clients who have severe mental health symptoms and severe substance use/addiction issues, which require a significant amount of time and energy being spent to maintain safety and keep clients in the treatment program. Often we are able to support and stabilize clients, but the majority of our time is used just to provide stability, rather than in-depth treatment, due to the severe needs.

VI. FY 2019-20 Projections of Clients to be Served: We are moving to Drug-Medi-Cal funding, and the residential stays are more limited. We project to serve approximately 250-275 clients.

VII. FY 2019-20 Program or Service Changes: Our program is switching to SUD DMC-ODS funding, which is a different system of care with different requirements. We still intend to provide co-occurring treatment to clients and support both substance use and mental health services.

FY 2019-20 MHSA PLAN UPDATE
COMMUNITY SERVICES & SUPPORTS (CSS) UPDATE REPORT

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 17

PROVIDER NAME: Horizon Services, Inc.

PROGRAM NAME: Residential Treatment for Co-Occurring Disorders- Chrysalis

Program Description: Chrysalis, a Program of Horizon Services, Inc. provides treatment services, care and supervision to meet clients needs in a safe and healthy home-like group living environment. Services include: (a) Comprehensive Assessments and Treatment Plans (b) Individual and Group Counseling (c) Crisis Intervention and Medical Emergency (d) Planned Activities (e) Family Counseling (f) Community Support System Development (g) Pre-Vocational or Vocational Counseling (h) Client Advocacy (i) Socialization Activities (j) Community Living and Interpersonal Skills Development. Structured services are available seven days a week, morning, afternoons and evenings.

Target Population: Chrysalis offers a 16-bed, community based residential treatment program for service participants who identity as female, 18-59 years old who are affected by substance use and mental health related problems.

I. FY 2018-19 Outcomes:

a. **Number of unique consumers/clients served:** 94
b. **FY 2018/19 Impact:** Clients have reported they have a voice, they are at a safe space, that they matter. They have also reported that our staff are respectful, and knowledgeable in both SUD and MH issues. The information they receive from groups and the structure provided has helped boost their self-confidence, self-esteem, self-worth and self-efficacy.

   Client story: 40 yr. Old AA female with one adult child and a partner. She reports trying several times to stop using her drug of choice (cocaine, benzo's and cannabus) her diagnosis was Major Depressive Disorder. Client used substances to cope with her feelings of depression and her use became habitural. Before entering program client did not have the tools to maintain a blanced life. Being in Chrysalis allowed the client to obtain coping skills, structure in her life, and she began addressing her mental health issues and was able to process what was standing in the way of her living a healthy lifestyle by makeing good choices. She gained a stronger relationship with her partner. She was able to be a more stable parent for her adult child. She learned how to set boundaries and restored her relationship with her family.

II. Please describe ways that the program strives to:

a. **Reduce mental health stigma:**
   We education clients about what stigma is. We discuss and explore how the stigmas affect clients. We name it in order to facilitate an open discussion. We educate family members about mental health and the stigmas.
b. **Create a welcoming environment:**
   We have art work that welcomes different cultures and identities. We as staff introduce ourselves to new intakes in order to make them feel comfortable. We create an environment that makes people comfortable with the pronouns that they identify with. We discuss welcoming behaviors in groups. Clients and staff meet once a month in order to create a community environment.

FY 2019-20 MHSA PLAN UPDATE
COMMUNITY SERVICES & SUPPORTS (CSS) UPDATE REPORT

III. Language Capacity for this program: Tagalog**,** English**,** Portuguese**,** French**,** Spanish (not fluent)**,** Urdu and Hindi. We also have access to the Language Line Solution.

IV. FY 2018-19 Additional Information: We have found that more co-occurring program are needed. We have been reviewing and changing how retention effects the program and the clients we serve. We have been working with Dr. Mee-Lee in prepreation for DMC-ODS.

V. FY 2018-19 Challenges:

- Places to refer people out to other co-occurring facilities
- Challenge in getting clients who are not an Alameda County Medi-Cal client transferred
- Getting medication, seen be a psych doctor
- Santa Rita not sending clients with no meds and TB test
- Clients being referred without having information about the program
- Not having other co-occurring programs to transfer to when Chrysalis is not an appropriate program
- Affordable SLE's when clients complete the program

VI. FY 2019-20 Projections of Clients to be Served: Effective 7/1/2019 Chrysalis is a DMC-ODS program

VII. FY2019-20 Program or Service Changes: Effective 7/1/2019 Chrysalis is a DMC-ODS program

FY 2019-20 MHSA PLAN UPDATE
COMMUNITY SERVICES & SUPPORTS (CSS) UPDATE REPORT

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 18

PROVIDER NAME: BACS

PROGRAM NAME: Wellness Centers

Program Description: Wellness Centers provide a welcoming entry point for outpatient services for individuals who are unserved or underserved by the mental health system. They provide step-down service for individuals transitioning from ACBH specialty mental health services in an environment of inclusion and acceptance in facilities that are commonly managed and staffed by consumers who provide or arrange for peer support. Wellness Centers are contracted providers who perform outreach and engagement; offer outpatient services such as mental health services, case management/brokerage, crisis intervention, medication support/dispensing; provide peer support and wellness services; and Individual Placement and Support (IPS) Supported Employment services.

Target Population: The BACS Wellness Centers provide services to adults (ages 25+) experiencing mental health challenges. These individuals may or may not be currently enrolled in ACBH specialty mental health programs (such as Service Teams, Full Service Partnerships, etc.). * There is also a Wellness Center provided by BACS that provides services to TAY (ages 16-24).

Additional Requirements for IPS Supported Employment

Contractor shall work with individuals who have expressed interest and motivation in pursuing competitive employment, regardless of their employment readiness, diagnoses, symptoms, substance use history, psychiatric hospitalizations, homelessness, level of disability, or legal system involvement.

I. FY 2018-19 Outcomes:

a. **Number of unique consumers/clients served:** In addition to a large number of partners who participated in the Wellness Center programs, the following are the client counts for Mental Health Services described:
   - Towne House Wellness Center:
     (1) Case Management Clients: 32
     (2) Med Management Clients: 53
   - Hedco Wellness Center:
     (1) Case Management Clients: 37
     (2) Med Management Clients: 59
   - South County Wellness Center:
     (1) Case Management Clients: 40
   - Valley Wellness Center:
     (1) Case Management Clients: 35

b. **FY 2018-19 Impact:** Some of the programs we have for our participants include employment coordination, housing coordination, case management, Psychiatric medication management, health services through Health Care for Homeless, health education through Cal State East Bay Nursing students, 1 on 1 support, socialization and other skills groups, cultural awareness activities, safety drills, community building activities and events (such as meals, holidays, birthday celebrations), AA meetings, NA meetings, NAMI meetings, SSI Advocacy trainings, referrals to specific services (housing, employment, medical, etc.), include incorporating DBT

principles into our groups, more robust social skills training, increased movement exercises, creating a more welcoming and functional space, and adding a new FSP program, and transportation to and from the center. Some of the special events we hosted this quarter include Family & Friends Night, and a Graduation BBQ.
We also incorporated IPS services into our program on a regular basis. Our on-site Employment Coordinator (EC) runs a weekly Employment group, teaching all participants the skills needed to search, apply for, and maintain employment. Our EC and Wellness Center staff followed up on these groups by providing individual support on creating resumes, shopping for professional attire, and preparing for job interviews. Our EC planned and hosted employment fairs, and supported our participants in engaging in employment fairs and on-site recruitment events (OSR's) on a weekly basis. We were able to support participants in finding regular employment, enrolling in Trade Schools, and in traditional Academic Schools. Our EC made many direct employer contacts on behalf of our participants throughout the year.

II. Please describe ways that the program strives to:

a. **Reduce mental health stigma:** BACS hires a peer and family partner workforce that ensures that mental health stigma is eradicated from its service delivery system. BACS partners with NAMI, FERC, POCC, and Office of Consumer Empowerment to fight and eradicate the stigma associated with mental illness.
b. **Create a welcoming environment:** BACS utilizes the Welcoming Toolkit that was created by BHCS over five years ago and has an in-house design team to ensure all program locations are welcoming, warm, vibrant, colorful, culturally inclusive, and responsive as well as accessible. BACS has consumer councils for the decorating of the centers. All sites and locations ensure that money is spent on keeping the facilities modern, warm, and inclusive. Additionally, Lavender Seniors certified BACS's sites as LGBTQ inclusive.

III. Language Capacity for this program: English, Spanish. Additionally, BACS access to all threshold languages in-house through BACS' bilingual pool of on-call staff.

IV. FY 2018-19 Additional Information: We partner on a regular daily basis with many other community service providers to support our participants. Some of our regular community partners include AA, NA, NAMI, Abode Housing, Health Care for Homeless, Men of Color, Cal State East Bay Nursing Students, FACES, Alameda Food Bank, local food and clothing stores for donations, Love Never Fails clothing store, Abode Housing, Bonita House, and local Board & Care homes to support our participant's in managing housing issues. We hosted Occupational Therapist Interns from Samuel Merritt school.

V. FY 2018-19 Challenges: Managing participant behaviors, specifically substance use and the interpersonal issues that frequently occur between regularly attending participants and new participants that are acclimating to the culture of the program. Another challenge has been having participants who stay outside the center after hours because it is a safe and familiar place for them, this can lead to disturbances for our neighbors and trash / waste outside our building.

VI. FY 2019-20 Projections of Clients to be Served: N/A

VII. FY 2019-20 Program or Service Changes: None

FY 2019-20 MHSA PLAN UPDATE
COMMUNITY SERVICES & SUPPORTS (CSS) UPDATE REPORT

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 18

PROVIDER NAME: Bonita House

PROGRAM NAME: Wellness Centers

Program Description: Wellness Centers provide a welcoming entry point for outpatient services for individuals who are unserved or underserved by the mental health system. They provide step-down service for individuals transitioning from ACBH specialty mental health services in an environment of inclusion and acceptance in facilities that are commonly managed and staffed by consumers who provide or arrange for peer support. Wellness Centers are contracted providers who perform outreach and engagement; offer outpatient services such as mental health services, case management/brokerage, crisis intervention, medication support/dispensing; provide peer support and wellness services; and Individual Placement and Support (IPS) Supported Employment services.

Target Population: The Bonita House Wellness Center provides services to adults (age 25+) experiencing mental health challenges. These individuals may or may not be currently enrolled in ACBH specialty mental health programs (such as Service Teams, Full Service Partnerships, etc.).

Additional Requirements for IPS Supported Employment:

Contractor shall work with individuals who have expressed interest and motivation in pursuing competitive employment, regardless of their employment readiness, diagnoses, symptoms, substance use history, psychiatric hospitalizations, homelessness, level of disability, or legal system involvement.

I. FY 2018-19 Outcomes:

a. **Number of unique consumers/clients served**: Total units of service for FY 2018-19 was 14,448, exceeding target by 145% of MHSA Outpatient Goal of 8,400. 108 total current active enrollees. 765 =70% of unique consumers target met.
b. **FY 2018-19 Impact:** Develop members/participants satisfaction survey. Measurement of progress towards members/participants self-identified goals. Measurement of members/participants employment placement rate.

II. Please describe ways that the program strives to:

a. **Reduce mental health stigma:** Inclusive, Non-judgmental, trainings/interventions, avoidance of clinical language and jargon with focus on equality in/toward wellness. Implementation of Cultural Competence/Humility amongst staff.
b. **Create a welcoming environment:** Person- centered needs exploration/ triaging/ linkage/ service delivery. "Casa culture" incorporates inclusion, respect, non-judgement, focus on personal growth, and communal support(s). Staff engagement by meeting/greeting every person that enters Casa U Program.

III. Language Capacity for this program: English and Spanish.

IV. FY 2018-19 Additional Information: <u>None</u>

FY 2019-20 MHSA PLAN UPDATE
COMMUNITY SERVICES & SUPPORTS (CSS) UPDATE REPORT

V. FY 2018-19 Challenges: Many members only participate in "Wellness Activities" and are not Outpatient billable as they already have Case Management elsewhere.

VI. FY 2019-20 Projections of Clients to be served: Goal is to meet or exceed current totals.

VII. FY 2019-20 Program or Service Changes: Terrence Cole resigned as Program Director. Joshua Paulos new and current Program Director for both Casa U and BAWC Wellness Programs. Mr. Paulos brings with him 17 years' experience, ranging from providing Outpatient Education and Diversion Services for criminal justice youth and adults of all ages to working with MHSA funded Assertive Community Treatment and Crisis Emergency Response Teams at the County level specific to high need/ at risk adults. An East Bay native, born and raised- Joshua earned 4 degrees from California State University East Bay, an undergraduate double major in Psychology and Human Development with a minor in Women's Studies, as well as his Master's degree in Social Work.

COMMUNITY SERVICES & SUPPORTS (CSS) UPDATE REPORT

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 18

PROVIDER NAME: Network of ACNMHC

PROGRAM NAME: Wellness Centers

Program Description: Wellness Centers provide a welcoming entry point for outpatient services for individuals who are unserved or underserved by the mental health system. They provide step-down service for individuals transitioning from ACBH specialty mental health services in an environment of inclusion and acceptance in facilities that are commonly managed and staffed by consumers who provide or arrange for peer support. Wellness Centers are contracted providers who perform outreach and engagement; offer outpatient services such as mental health services, case management/brokerage, crisis intervention, medication support/dispensing; provide peer support and wellness services; and Tenant Support Services (TSP) for those with housing insecurity.

Target Population: Network of ACNMHC Wellness Centers provide services to some TAY and Adults (ages 18+) who identify as being behavioral health consumers in programs funded through ACBH. They make it a priority to serve behavioral health consumers who: Have histories or current conditions of psychiatric disabilities; are identified or labeled as having severe mental illness (SMI) or severe mental stress; have experienced (or are at risk of experiencing) repeated psychiatric hospitalizations, treatment placements, or episodes of incarceration in the criminal justice system; are experiencing housing insecurity; and those who are experiencing problems with alcohol and/or other drug abuse.

I. FY 2018-19 Outcomes:

a. **Number of unique consumers/clients served:** 16,268
b. **FY 2018-19 Impact:** Provider declined to state.

II. Please describe ways that the program strives to:

a. **Reduce mental health stigma**: The Network reduces mental health stigma through active peer support, community engagement/consumer input and consumer employment. Housing advocacy and intensive case management provided by individuals who have lived experience receiving mental health services mold recovery.
b. **Create a welcoming environment**: The Network strives to maintain a welcoming environment by offering a warm presentation, possibly a program volunteer, is there to greet consumers when they arrive and a safe and clean waiting space. Minimally, all of our spaces provide water, coffee and snacks. All of our programs have brochures about the agency available as well as a variety mental health recovery motivated materials.

III. Language Capacity for this program: English and minimal Spanish. Materials provided in other languages besides English and Spanish.

IV. FY 2018-19 Additional Information: None

V. FY 2018-19 Challenges:

- Staff shortage / retention: We are developing a more suitable staffing structure to address this challenge
- Increased operating costs: Rent, Fringe benefits, Liability insurance
- Reduced service deliverables: This may impact the quality of what services are being offered

VI. FY 2019-20 Projections of Clients to be Served: 10% increase in consumer contact. We have increased our contacts by at least 10% annually.

VII. FY 2019-20 Program or Service Changes:

- Tenant Support Program: WRAP Groups - 5 cohorts annual off site / 1 weekly open WRAP group on site
- BestNOW!: The training program will Mental Health Peer Support and Substance Use Disorder. This will include internship opportunities
- Reach Out: Increase curriculum and wellness activities

FY 2019-20 MHSA PLAN UPDATE
COMMUNITY SERVICES & SUPPORTS (CSS) UPDATE REPORT

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 19

PROVIDER NAME: Hiawatha Harris, M.D., Inc.

PROGRAM NAME: Pathways to Wellness Medication Clinics

Program Description: Pathways to Wellness provides the following clinic-based services based on the acuity client of needs to promote successful transition of patients to primary care; 1. Medication Support Services including initial assessment and follow-up assessment; 2. Issuing medication prescription(s) for the right drug therapy for client; 3. Administration of injectable medication, when applicable; 4. Evaluation and monitoring including consultations with physicians, clients and family members as authorized by the client. Face-to-face evaluation and monitoring for possible drug interactions, contraindications, adverse effects, therapeutic alternatives, allergies, over/under dosing, polypharmacy, side effects, dietary conflicts or any other medication related issues; 5. Mental Health Services including assessment, collateral, plan development, individual rehabilitation, brief individual and/or group therapy, case management/brokerage and crisis intervention services.

Target Population: Pathways to Wellness provides services to children (5-9 years old), adolescents (10-17 years old), and adults (18-59 years old) who have moderate to severe mental illness impairments resulting in at least one significant impairment in an important area of life functioning. All clients must meet specialty mental health criteria with impairments in the moderate to severe range. All clients are referred by Alameda County Acute Crisis Care and Evaluations for System-Wide Services (ACCESS). Services are provided in North County, South County and East County, located in Oakland, Union City and Pleasanton.

I. FY 2018-19 Outcomes:

a. **Number of unique consumers/clients served:** 3,427
b. **FY 2018-19 Impact:** The impact of providing services over the last year has positively impacted our clients and our community. Clients have received ongoing medication management, crisis intervention, engagement services, brokerage services to receive resources and we were able to improve client education and understanding of medications this year. We also reduced incarcerations and hospitalizations over the last year. This year our clinics were able to increase PCP collaboration.

II. Please describe ways that the program strives to:

a. **Reduce mental health stigma:** Pathways to Wellness utilizes client centered assessment, strength-based services, trauma informed care, and training.

   Assessment: is an ongoing service activity of gathering and analyzing information about the client, from multiple sources to help identify behaviors serve in the client's environment. Assessment includes, but is not limited to, one or more of the following: mental status determination, analysis of the client's clinical history; gathering relevant cultural issues, analysis

of behaviors and interpersonal skills, a review of family dynamics and diagnosis. Assessment tools include observation, interviews, testing and a review of history.

Trauma Informed Care: In alignment with the MHSA standards of treatment and care, Pathways to Wellness utilizes trauma informed care which includes program participant empowerment and choice, collaboration among service providers and systems, ensuring physical and emotional safety and trustworthiness for program participants. Key ingredients of providing comprehensive trauma informed care involves both organizational and clinical practices. Our policies, practiced, trainings, and culture recognizes the impact of trauma our clients suffer from.

Strength Based Model: Our Strengths Based Model uses a set of values and philosophy of practice that encourages clients to become experts in their own mental health recovery. This includes the potential to recover from adversity through identified strengths, natural supports, community resources and other opportunities. Program staff assists clients in assessing their strengths, establishing meaningful goals, and developing a recovery plan. Pathways to Wellness encourages program clients to recover from mental health and reclaim their lives. Our focus is on strengths rather than deficits as we help identify and leverage existing community resources. We encourage the participant to be an expert of their own recovery. We encourage the program staff - participant relationship as primary and essential with both working together as co-partners.

Training: We provide ongoing culturally responsive training in order to better engage and serve African American consumers which represents the largest client population at Pathways. These trainings are provided to both our staff and to our community. We train providers about the complexity of trauma within the African American population and how to best serve their psychiatric and biopsychosocial needs.

b. **Create a welcoming environment:** Our welcoming environment includes providing a client-driven, recovery-oriented, strength-based, trauma-informed, culturally and linguistically responsive, and comprehensive community-based specialty mental health services. We support adults ages 18 years and older living with a serious mental illness, at risk of or experiencing homelessness, who may also have a co-occurring substance use disorder, and/or who may be engaged in the criminal justice system. Using the principles of recovery-oriented care, trauma-informed care, culturally responsive services, and the Strengths Model to guide program practices and service delivery. Our services implement a phased approach with the provision of intensive services during the early phase of treatment. We see clients frequently within their first 90 days in order to ensure they are out of crisis and stabilized on their medications, and have community resources. Our waiting rooms are set up so that clients may experience a welcome home environment with coffee, sometimes food offered, clothing and food drives, as well as our yearly mental health picnic for clients, and our consumer council that was created. Clients are provided with art supplies while they wait for their appointments and are met with our engagement team to ensure they have their needs met and are welcomed.

FY 2019-20 MHSA PLAN UPDATE
COMMUNITY SERVICES & SUPPORTS (CSS) UPDATE REPORT

III. Language Capacity for this program: Language capacity for Pathways to Wellness has multiple language options. We offer a language hotline where clients can have any language translated so that their provider will be able to provide services. In addition, we are a diverse agency with multiple staff speaking multiple languages including Spanish, Farsi, Punjabi, Tagalog, Mandarin, Russian, and several other languages.

IV. FY 2018-19 Additional Information: We were able to improve our referral to 1st appointment time by adding on a designed Intake Physician and by offering transportation to and from the clinic for all new clients.

Our children's services contract with BHCS ended on December 31, 2018 after 19 years of providing children's services in Alameda County. We discharged and properly transitioned over 260 children, youth and adolescents to Children's Hospital, Eden and Valley facilities.

V. FY 2018-19 Challenges: Over the last year, re-gentrification has created a significant impact on our communities. Homelessness has increased exponentially which has increased the impact of our client's mental health. Our clients have become absent of homes and safety within the only community that they know. Clients have also been impacted by increases in the cost of living especially for basic needs such as food, healthcare costs, childcare, and transportation without an increase in SSI, Medi-Cal, or GA benefits. Our clients are in a state of survival unlike ever before. These stressors have increased the impact of our client's mental health which has made their symptoms more severe. As a result, clients are having more crisis incidents, more complex trauma symptoms, and an increase in overall health disparities. Pathways to Wellness has been working hard to connect clients to services but it has been difficult especially when finding housing resources. We also still continue to struggle with discharging high volumes of clients to lower level of care due to the inability for PCPs to take our clients.

VI. FY 2019-20 Projections of Clients to be Served: 3,500

VII. FY 2019-20 Program or Service Changes: Over the next year, we are implementing a client council that will consist of clients who represent North County, South County and Tri-Valley Pathways clinics, a new intake process, and a robust case management team. We are also starting walk in clinic for new clients to increase capacity for clients in need of medication support services. We are working to reducing our wait times and increasing the amount of times we see clients each month especially in the initial assessment phase. This will increase our quality of client care, increase engagement, and reduce no-show rates.

FY 2019-20 MHSA PLAN UPDATE
COMMUNITY SERVICES & SUPPORTS (CSS) UPDATE REPORT

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 19

PROVIDER NAME: Telecare- STEPS

PROGRAM NAME: Medication Support Services * Short-term Case Management Services**

Program Description: STEPS of Alameda County is a short term, intensive community support service for individuals who suffer from a mental illness, many of whom would otherwise require extended care in institutional settings. Services are designed to enhance the lives of individuals living with mental illness and guide them on their healing process. The mission of STEPS is to facilitate the transition of high risk, hard-to-place Alameda County Behavioral Health clients into the community while reducing their length of stay in Alameda County psychiatric facilities.

Target Population: Adults (ages 18-59) diagnosed with a severe mental illness. STEPS' goal is to serve high utilizers of Alameda County mental health services. Members referred to STEPS will have utilized at least three psychiatric emergency room visits and/or at least one month of inpatient psychiatric care within the past year. Priority will be given to members who have met these criteria for 2 years in a row.

I. FY 2018-19 Outcomes:

a. **Number of unique consumers/clients served:** 69 clients served
b. **FY 2018-19 Impact:** 3,304.66 hours billed services, 239.04 hours outreach services
   The STEPS program provides support to individuals around re-entry to the community from long-term hospitalizations, as well as support to reduce immediate risk of deterioration in the community. We assist clients with connecting to PCP/psychiatry services/on-going case management, coach and instruct clients around developing and practicing coping strategies from Evidenced Based Practices, such as DBT, CBT, Seeking Safety, use Motivational Interviewing techniques to reduce functional impairments and problematic behaviors in the community, explore and locate safer housing options including applying for low-income subsidized housing, connect with community groups and activities including employment services and SUD services, provide psycho-education around understanding diagnosis and symptom management, understanding and accessing resources and services such as food pantries, free resources, and transportation, and increasing self-advocacy skills.

II. Please describe ways that the program strives to:

a. **Reduce mental health stigma:** STEPS program is committed to treating all of our partners, their families, and community providers with respect and dignity. All staff are trained in using and adopting Telecare's Recovery Centered Clinical System approach. This approach promotes our partners hopes and dreams, and we focus treatment services to collaborate with their vision. We work with area providers to support our partners connecting with peer programs, such as Best Now, PEERS, and POCC to decrease internalized stigma and increase feelings of empowerment.
b. **Create a welcoming environment:** STEPS program provides the vast majority of our services in the community, but we work to ensure our office environment is clean, comfortable, and welcoming to all partners. The STEPS team engages with our partners through a non-judgmental, hopeful, respectful, and caring attitude. All staff on the STEPS team have been trained in the Telecare Recovery Centered Clinical System, which promotes a culture of

awareness of individual uniqueness, motivation, respect and dignity. We approach services from a power-with model and engage collaboratively with partners on their recovery journey. All staff have participated in the "Welcoming Spaces" training provided by Bruce Anderson. We also offer member celebrations twice a year. During the summer, we host a member picnic to provide an opportunity to celebrate successes, develop pro-social relationships, and enjoy a fun filled day in a beautiful place. During the fall, we host a Thanksgiving celebration which is catered with all the thanksgiving favorites to ensure our partners have an opportunity to spend the holiday in a supportive and caring environment.

III. Language Capacity for this program: STEPS program uses a Language phone line, which offers 200+ language options via a telephone interpreter.

IV. FY 2018-19 Additional Information: The STEPS program maintains a decrease in hospitalizations, decrease in incarceration/recidivism rates, increase in acquisition of state and federal benefits, improved housing stability by number of days housed, increase in medication maintenance, increased participation in meaningful activities and sense of independence, and 99% connection at least once with PCP and psychiatry services.

V. FY 2018-19 Challenges: It continues to be challenging at times to coordinate with multiple specialty medical services due to time delays and the complexity of organizing multiple providers. Housing continues to be a challenge. This year we have seen an increase in average length of stay for partners, possibly due to the increase in community referrals in crisis who need a longer stay to stabilize. Another challenge over the last few months, is last minute changes in ACCESS case management referrals. The service flow from subacute facilities to FSP level care has improved and over the last several months, a number of referrals initially referred to STEPS have ultimately been assigned to FSP teams, so we are unable to work with them in the community. This has contributed to not reaching our expected census this year.

VI. FY 2019-20 Projections of Clients to be Served: 75

VII. FY 2019-20 Program or Service Changes: None

FY 2019-20 MHSA PLAN UPDATE
COMMUNITY SERVICES & SUPPORTS (CSS) UPDATE REPORT

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 20

PROVIDER NAME: Alameda County Vocational Services

PROGRAM NAME: Individual Placement Services (IPS)

Program Description: BHC Vocational Services - IPS is a part of the Adult System of Care for Behavioral Health Care Services that is imbedded in 15 different county operated and community based service teams and specialty mental health programs, including Conditional Release, the TRUST Clinic, Asian Health Services, Casa Del Sol and La Familia. Alameda County Vocational Services also oversees 7 different CBOs that have incorporated IPS into their service delivery.

Our service approach is to partner with the consumers and engage them around their unique interests and needs in finding a job, meet them in their community to identify employers, apply for jobs and assist with retention, while continuing to collaborate with their clinical team and significant others to aid in their success. The IPS model is seen as a treatment intervention.

After a consumer is working, providers continue to support the individual until the job is secure and s/he is satisfied with the job match. If they want a different job or lose the one secured, we keep looking for jobs to help find a better fit. There is a "zero exclusion" approach to recruiting consumers for services, which means that as long as they are motivated to work and have expressed interest, they will be engaged despite any presenting barrier.

Target Population: Youth (16-17 years old), Transitional Age Youth (TAY- 18-24 years old), Adults (18-59 years old) and Older Adults (60+ years old) in finding and keeping competitive work using the Evidence Based Practice of Individual Place and Support- Supported Employment. IPS services span across Alameda County: north-county, mid-county, Tri-Valley, and Tri-City locations.

I. FY 2018-19 Outcomes:

a. **Number of unique consumers/clients served:** 275
b. **FY 2018-19 Impact:** Vocational Services is reviewed annually based on the 25 standard Fidelity Review by external reviewers and has sustained a “Fair” level of fidelity. (115 - 125 = Exemplary Fidelity, 100 -114 = Good Fidelity, 74 - 99 = Fair Fidelity, 73 and below = Not IPS).

   Has a 37% job placement rate for the fiscal year. Competitive employment rate percentage is the number of clients in the IPS program who worked a competitive job in the community (n=103) divided by the total number of people in the IPS program (n=275). Benchmarks set by the Westat IPS Collaborative include 30% minimal standard, 40% good standard, and 50% exemplary standard.

   Helped consumers start 63 new jobs during the FY 18-19 as well as maintain 64 positions with existing employers, for a total of 127 jobs (see list of employers and positions in appendix).

II. Please describe ways that the program strives to:

a. **Reduce mental health stigma:** The majority of individuals (~65%) with serious mental illness receiving specialty mental health services express a desire to work, yet within the BHC systems of care, fewer than 3% of people with serious mental illness have access to evidenced-based IPS

employment services. The employment rate of specialty mental health consumers in California is estimated to be only 10%. In other words, 90% of consumers are unemployed (as compared to only 3% of the general regional population). To compound matters, an even smaller fraction of employed consumers are actually working full-time. Facts such as these only reinforce the widespread stigma that mental health consumers are “too sick,” “too unreliable/unpredictable,” or “too dangerous” to work.

Because of employment related stigma, consumers are typically steered toward volunteer positions or sheltered work where they are paid a fraction of minimum wage while performing trivial assignments/tasks. They are generally isolated from the rest of the workforce, further worsening their experience of stigma.

The BHC IPS programs help consumers enhance their lives by supporting people fulfill a universal human need of having purpose. Like anyone else, work helps boost consumers’ self-esteem and provides an opportunity to be active in the workforce and to be contributing societal members. At work, consumers have an opportunity to develop meaningful relationships with co-workers and to engage with the public. Through work, consumers are able to dispel the fear, uncertainty and doubt that can be directed toward them. Employment Specialists help reduce stigma as well, by introducing employers to qualified employees who can contribute to their businesses in many ways. Consumer job seekers and employees, along with IPS workers are ambassadors of mental health. They help reduce stigma in workplace settings every day.

BHC – Vocational Services also sponsored an IPS conference this last fiscal year which welcomed 12 different counties through the state and over 150 providers to learn more about how to make competitive work accessible to our population using IPS.

b. **Create a welcoming environment:** BHC Vocational Services strives to create a welcoming environment and promote the idea that work supports recovery. For example, over 100 mental health consumers, workers and natural supports came together to celebrate employment successes of IPS Program participants throughout the BHC system during the Annual IPS Participant Celebration event. This annual event highlights people’s achievement and progress toward their employment goals, and also acts to inspire others to consider obtaining and maintaining competitive/mainstream employment as part of their wellness. Consumer Back-to-Work testimonials, a buffet lunch, raffle prizes, and inspiration stations were all a part of the event.

   In the everyday work, Vocational Services workers embrace the philosophy of figuratively and literally “meeting people where they are.” That is, workers understand the importance of building relationships with consumers through understanding their values, lens through which they view the world, their unique style and personality, needs, emotions, dreams for a better future, and connecting in a way that is effective for them. Vocational Services workers do this by listening, observing, affirming, and asking questions at the right time. To reduce logistical barriers and ensure consumers feel safe and secure, workers meet with people in community settings largely determined by consumer preference.

III. Language Capacity for this program: ACBH Vocational Services has on staff direct service providers who are native speakers of Spanish and Korean. Services are provided to consumers regardless of language capacity (incl. sign language services for people who are deaf or hard of hearing), and make use of the available "Language Line" interpretation or sign language interpretation services as necessary.

IV. FY 2018-19 Additional Information: None

V. FY 2018-19 Challenges: The biggest challenge in this fiscal year has been to fill vacant staff and supervisory positions. Staff have retired and promoted to better jobs faster than the civil service human resource department can keep up. At the end of FY 18-19, 6 out of 17 direct service positions were vacant (35% unit vacancy rate).

VI. FY 2019-20 Projections of Clients to be Served: 275

VII. FY2019-20 Program or Service Changes: Vocational Services has three divisions – a direct service, county operated, unit (which serve the 15 BHC programs), a technical and training unit which reviews other community based programs that are using the IPS model, and the oversight of the CalWORKS Mental Health Program – which recently contracted three providers (Family Paths/CHAA, Bonita House and La Familia/ Fremont FRC) to both treat barriers to employment and assist recipients to find work using IPS. There are currently 7 CBO contracts (down from 9 last FY) that include IPS service programs which are reviewed annually and provided with technical assistance by Vocational Services. Two CBO agency contracts were not renewed by BHC (One Service Team and one Full Service Partnership).

Appendix

List of Employers:

99 CENT STORE
ALAMEDA COUNTY
OFFICE OF THE
REGISTRAR
ALAMEDA UNIFIED
SCHOOL DISTRICT
ALLEN TEMPLE
AMAZON
AMAZON
FULFILLMENT
AMAZON WHOLE
FOODS
AMC THEATRE
AMERICA MEDIA
AMERICAN
PORTWELL
TECHNOLOGY
ANN TAYLOR
RETAIL STORE
BERKELEY
RECYCLING CENTER
BRIGHTVIEW
LANDSCAPING
SERVICES
BURGER KING
CABULANCE
COMFORT
CARDENAS
MARKETS
CARE.COM
CARL'S JR
CAROL FERREYERA
CDS
COST PLUS WORLD
MARKET
COSTCO
DEPT. OF REHAB
DOORDASH
ELEPHANT BAR
E-RECYCLE
FEDERAL EXPRESS
FOOD MAXX
GRAND AVENUE
SHELL STATION
GROCERY OUTLET
HARPERS MODEL
HOME
HEALTHFLEX HOME
HEALTH SERVICES
HOBBY LOBBY
HOME DEPOT
HOODLINE
JOHNNY ROCKETS
JOHNSON SECURITY
K MART
KFC
LA CONCEPCION
LABOR FINDERS
LANDMARK
STAFFING
LIBERTY TAX
LITTLE CEASARS
PIZZA
LUCKY'S
MCDONALD'S
METRO PCS
MINTED
MOBILE CAR WASH
MOBILE GAS
STATION
OAKLAND UNIFIED
SCHOOL DISTRICT
PAPA JOHN'S PIZZA
PARK PLACE
DESIGN, LLC
PAULINE PURCELL
INC.
PEPSI BEVERAGES
COMPNAY
PET SUPPLIES PLUS
PIZZA HUT
PLUCKED CHICKEN
& BEER

PUP TOWN STAY AND PLAY
PUPTOWN DOG DAYCARE & BOARDING
QUANTUM MARKET RESEARCH
RITE AID
ROCKY MOUNTAIN RECREATION CO.
ROSS DRESS FOR LESS
SAFEWAY
SALVATION ARMY
SAUL'S RESTAURANT
SEASIDE REFRIGERATED TRANSPORT
SHELL GAS STATION
SPROUTS
STAR PROTECTION AGENCY
SWEET TOMATOES
TELECOM INC.
THE COLLEGE INTERNSHIP PROGRAM
THE VILLAGE AND HAYES VALLEY
TJ MAXX
TRADER JOES
UBER
UPS
VICTORIA CARE HOME
WALMART
WENDYS

List of Positions include:

Activities Assistant
Architectural Draftsperson
Associate
Auto Mechanic Trainee
Care Giver
Cart Attendant
Cashier
Clerical Specialist
Computer Assembler
Courtesy Clerk
Crew Member
Custodian
Customer Service Rep
Door Dasher
Demo Person
Dog Handler
Driver
Mover
Flagger
Food Service Worker
Front Desk Reception
Gardner
Grocery Clerk
Merchandiser
Hostess
Independent Contractor
Inspector
Janitor
Legal Assistant
Lot Attendant
Lot Customer Service Associate
Merchandiser
Model Home Cleaner
Parking Lot Attendant
Prep. Cook
Processing Clerk
Produce Clerk
Receptionist
Registered Nurse
Retail Clerk
Sales Associate
Sales Representative
Security Guard
Service Specialist
Shopper
Sign Holder
Sortation Associate
Staging hand
Stock Clerk
Stocker
Substitute Paraprofessional
Summer Camp Counselor
Team Member
Telephone Interviewer
Truck Loader
Utility Clerk
Com Vacuum Cleaner
Waitress
Warehouse Associate
Writer (Freelance)

FY 2019-20 MHSA PLAN UPDATE
COMMUNITY SERVICES & SUPPORTS (CSS) UPDATE REPORT

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 22

PROVIDER NAME: Multiple consultants with Bonita House as the fiscal sponsor

PROGRAM NAME: African American Wellness Hub Complex Planning Phase

Program Description: This is the first phase towards the development of an operational and working structure of a holistically focused Wellness Hub to serve the African American community.

Target Population: African American community in Alameda County.

I. Progress to date

ACBH listed this research and planning project in its FY 18/19 Plan Update under "changes/new projects". This project was approved by the Board of Supervisors in late FY 18/19. Since the approval date the local community consultants have begun working in partnership with ACBH on the deliverables listed in the project scope of work. These deliverables include:

- Identification of potential locations for the Wellness Hub,
- Data review of all existing reports and information regarding the mental health needs and assets for the African American community;
- Development of program and service components, including a detailed operational budget and staffing pattern;
- Space/location planning;
- Management structure recommendations;
- Identification and outreach to additional partners to develop institutional affiliations agreements and memorandums of understanding for services and supports for the Wellness Hub, and
- Planning status reports and final reports.

It is the goal that the planning and research efforts conducted during this 12 month planning process for the African American Wellness Hub Complex, will lead to future phases through a competitive procurement process through General Services Agency (GSA).

FY 2019-20 MHSA PLAN UPDATE
COMMUNITY SERVICES & SUPPORTS (CSS) UPDATE REPORT

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 23

PROVIDER NAME: REFUGE

PROGRAM NAME: Crisis Residential Services

Program Description: REFUGE offers a 24-Hour facility for TAY consumers in crisis. A supervised residential facility for mental health treatment program that includes full-day social rehabilitation services for TAY who need additional support as they step down from a restrictive setting into the community. REFUGE has 13 beds and offers residential treatment up to 6 months.

Target Population: REFUGE serves TAY consumers between 18 years of age and 25th birthday who are living in Alameda County (including those who are homeless or at risk for becoming homeless); are enrolled in Health Program Alameda County (HealthPAC County) or Full-Scope Medi-Cal eligible; who meet medical and service necessity criteria for specialty mental health services; require a transitional period of adjustment after a psychotic episode, and/or stepping down from hospitalization/restrictive setting before returning to the community; are ambulatory and free of communicable diseases; are able to participate in 4+ hours of group programming daily; who have the ability to pay for room and board (program can support client in obtaining benefits); and have been authorized for services by ACBH.

I. FY 2018-19 Outcomes:

a. **Number of unique consumers/clients served:** 6
b. **FY 2018-19 Impact: Creates an environment that:**
   - Normalizes the clients experiences
   - Foster new connections that are healthy and encouraging
   - Created structure in the clients day to day lives
   - Connected clients to resources in the community to help them after discharge

II. Please describe ways that the program strives to:

a. **Reduce mental health stigma:** As a community we cultivate an environment of acceptance. Educating the milieu about different diagnosis and even different experiences of clients with similar diagnosis.
b. **Create a welcoming environment:** Clients are invited to collaborate about meal planning and extra curricular activities that they enjoy doing together. Meals are often served family style and topics are discussed ranging from music to fashion. As an agency all staff are involved in the clients care and growth while in our program and are celebrated for their achievements. When someone is struggling it is common for peers to communicate with staff their concerns for their safety and mental health.

<u>Client Story:</u> Tiffany a 21 year old African American female entered our program in March 2019. She began experiencing audio hallucinations at the age of 16 but was so ashamed of the stigma attached to mental illness she refused to tell anyone and began to isolate due to her psychotic episodes. After battling with her depressive symptoms she attempted suicide and was hospitalized. She is diagnosed with Schizoaffective disorder In our program she has learned that life doesn’t have to be isolating and that she can live a normal life full of love and support. Her mother is an active support person and is willing to participate in any capacity as needed (she also struggles with her own mental illness).

Initially Tiffany was guarded when starting our day rehabilitation program, and after 2 months of treatment she began to share freely becoming a mentor to her peers. During her depressive episodes Tiffany would have a hard time communicating her feelings and staff would recognize that she was having a hard time due to the state of her room and difficulty getting out of the bed in the morning. She will be discharging in September and has successfully began adult school to complete her high school diploma and gained permanent housing. She has definitely been an inspiration to us all.

III. Language Capacity for this program: English and Spanish.

IV. FY 2018-19 Additional Information: Exploring ways to use the facility more creatively so that the clients have more variety in their treatment. (i.e. gardening). Would love to implemente a Kimbilio dollars program to create a system to teach the clients living skills and earning rewards to encourage good decision making and job skills.

V. FY 2018-19 Challenges: Getting clients to stay in group during an episode (depression, psychosis, etc.).

VI. FY 2019-20 Projections of Clients to be Served: 25

VII. FY 2019-20 Program or Service Changes: None

FY 2019-20 MHSA PLAN UPDATE
COMMUNITY SERVICES & SUPPORTS (CSS) UPDATE REPORT

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 24

PROVIDER NAME: Alameda County Behavioral Health

PROGRAM NAME: Schreiber Center

Program Description: The Schreiber Center (http://www.acphd.org/schreiber-center.aspx) is a specialty mental health clinic developed in collaboration with Alameda County Behavioral Health, the Regional Center of the East Bay, and Alameda County Public Health Department. The center is dedicated to serving the mental health care needs of adults with intellectual and developmental disabilities. The team of professionals specializes in supporting clients with complex behavioral, emotional, and/or psychiatric needs.

Target Population: The Schreiber Center serves the mental health care needs of adults (ages 18-59) and older adults (60+) with intellectual and developmental disabilities. The Schreiber Center also serves residents of Alameda County, ages 18 and up, who are clients of the Regional Center of the East Bay (RCEB). Clients must also meet the specialty mental health criteria and have a covered behavioral health care plan to be considered eligible for services.

I. FY 2018-19 Outcomes:

a. **Number of unique consumers/clients served:** 67
b. **FY 2018-19 Impact:** Schreiber Center clinicians have become competent practitioners with regard to comprehensive and accurate assessment and differential diagnosis for individuals with developmental and intellectual disabilities (DD/ID). Our competencies have grown such that the Schreiber Center team has been asked to provide clinical trainings to ACBH ACCESS program as well as both the TAY & Crisis systems of care. Clients continue to be better served on a *micro*-level at Schreiber Center clinic due to improved diagnostics which inform best-matched therapeutic and psychiatric treatment. Clients receiving ACBH specialty mental health services who have co-occurring DD/ID are also better served on a *macro*-level due to Schreiber Center clinicians sharing competencies with both the ACBH/Behavioral Health community of providers as well as the RCEB/Disabilities community of providers. Doing so has enhanced services on both sides and contributed to improved communication & collaboration between systems of care.

   A recent example of the *macro*-level impact occurred at the point of discharge for a transitional age youth leaving Villa Fairmont. This person had a diagnosis of bipolar affective disorder and a four-year history of psychiatric instability due to limited community supports. Rather than reflexively assume that RCEB case management services would adequately meet his needs, our colleagues at ACCESS and Villa Fairmount reached out to us for guidance. This client was assessed by a Schreiber Center clinician while he was still inpatient. It was determined that best-matched care would be a TAY FSP service team with Schreiber Center psychiatry. Because this individual had 14 acute psychiatric hospitalizations (including four months at Santa Rita's forensic behavioral health unit) the 1.5 year prior to this new plan – service providers were very concerned about the outpatient plan. The decision and services provided were determined a success, however, because the client needed only one psychiatric hospitalization during the 12 months following discharge from Villa Fairmont.

FY 2019-20 MHSA PLAN UPDATE
COMMUNITY SERVICES & SUPPORTS (CSS) UPDATE REPORT

II. Please describe ways that the program strives to:

a. **Reduce mental health stigma:** Schreiber Center provides community education about identifying signs/symptoms of mental health issues for family members and other professionals who serve individuals with DD/ID. We adapt standardized therapeutic tools and techniques for individuals with limited verbal capacity to express their needs. Training also includes education of prevalence of trauma in this vulnerable population – a mental health issue frequently undiagnosed and under-reported by individuals served at Schreiber Center.

b. **Create a welcoming environment:** All clients and visitors to Schreiber Center are treated with respect and dignity. When the clinic moved in May 2019, administrators made sure that waiting room bathrooms were accessible for our clients with mobility and wheelchair needs. Clinicians offer clients tea or water and the supervisor is working on acquiring a Safeway account in order to purchase some healthy snacks for hungry visitors. Clinicians have a variety of therapeutic tools to meet the needs of clients with varying developmental capacities.

III. Language Capacity for this program: Schreiber Center makes use of Lionbridge language line and in-person interpreters for assistance communicating with clients and their families. All languages can be served using these tools. Current clinical staff are all English-speaking.

IV. FY 2018-19 Additional Information: During FY 2018-19, Schreiber Center acquired a Temporary staff via ACBH TAP program and was able to cross-train her during the primary staff's maternity leave. Doing so enabled this single-clinician program to continue client services without disruption – and the census grew significantly in spite of the coverage need! In addition, the program now has a fully trained, back-up clinician with competencies needed to serve the vulnerable DD/ID population as needed.

V. FY 2018-19 Challenges: Small staff size and finite resources continues to limit the number of clients who can be served clinically. ACBH attempted to collaborate with RCEB on funding options with the hope of increasing capacity by adding one clinician by summer 2019. Unfortunately this proposition, which included shared funding, was not approved – and the program continues to function with one full-time therapist and one half-time psychiatrist. Schreiber Center will host an MSW student intern for fall 2019. Inviting an intern to join the team will increase capacity and contribute toward the development of a workforce that is competent to serve individuals with intellectual and developmental disabilities.

VI. FY 2019-20 Projections of Clients to be Served: 75

VII. FY 2019-20 Program or Service Changes: Schreiber Center offices were moved from Hayward to Oakland in May 2019. This change has been met with mixed response from clients and their families – some happy about convenience of the new location and some who ended treatment services as a result of a more urban setting. With the addition of a student intern, the program is considering launching a small therapy group to assess client and community interest. The clinicians are working on developing a short training outline to share with mental health providers re: best practices for assessment and treatment for individuals with developmental and intellectual disabilities.

FY 2019-20 MHSA PLAN UPDATE
COMMUNITY SERVICES & SUPPORTS (CSS) UPDATE REPORT

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 25

PROVIDER NAME: Fremont-PATH/Tri-City Health Care

PROGRAM NAME: Behavioral Health - Primary Care Integration Project

Program Description: Tri-City Health Care operates a Federally Qualified Health Center (FQHC) to provide co-located services at the Oakland Adult Community Support Center (OCSC) operated by ACBH. The project provides coordinated, integrated health care to adults with serious mental illness. The project is called "Promoting Access to Health" (PATH) and has a Wellness Program to provide group health education and encourage socialization.

Target Population: PATH services are offered to all adults (18-59) and older adults (60+) assigned to the service team at the support center.

I. FY 2018-19 Outcomes:

a. **Number of unique consumers/clients served:** 31
b. **FY 2018-19 Impact:** We have continued Primary Care service to clients of ACBHCS. Our enrollment numbers continue to increase and we have demonstrated success with the patients that attend their appointments. TCCS continues to transfer PATH patient's BH prescriptions to our PCP's responsibilities. This allows stable patients to be closed to ACBHCS and gives patients a sense of achievement and success, while at the same time not losing the comfort of familiar surroundings. The best aspect of this transition is that the primary care provider is still able to access the past psychiatrist and case managers on a regular basis if even a slight concern arises.

II. Please describe ways that the program strives to:

a. **Reduce mental health stigma:** See our response below.
b. **Create a welcoming environment:** We have strived to make our waiting room a comfortable and welcoming environment. We make sure to have healthy snacks and interesting, educational videos available. We have personal artwork posted on the walls that is provided by patients. They are invited to submit a picture that is drawn, colored, or photocopied; we then frame and hang the art in the waiting room. It gives our patients joy to see their submissions hanging and they come in with anticipation and curiosity to see what others may have submitted.

III. Language Capacity for this program: PATH provides services in English, Spanish, Punjabi and Hindi.

IV. FY 2018-19 Additional Information: None

V. FY 2018-19 Challenges: We continue to wait for AT&T to increase the bandwidth for our extended PATH site. We have been waiting for nearly a year. This is a serious challenge to our operations; due to the lack of bandwidth, our EHR system sporadically disconnects or slows to a crawl during clinic time. We also lose access to printing and telephone connections. This is extremely dysfunctional and it has caused us to lessen the number of patients we are able to see because every aspect of clinic can slow down or stop at any given time.

FY 2019-20 MHSA PLAN UPDATE
COMMUNITY SERVICES & SUPPORTS (CSS) UPDATE REPORT

We have also had challenges with transportation as Paratransit services have discontinued. We have found additional services through pharmacies and patient's insurance to try and make up for the loss.

VI. FY 2019-20 Projections of Clients to be Served: It is our hope to continue increasing our number of clients as they become available. We would like to get our visits up to at least 14 per clinic day but are unable to until the bandwidth is increased.

VII. FY 2019-20 Program or Service Changes: Provider Hillary Baldocchi, NP left our PATH program in April and was replaced with Anita Galhotra, NP. Anita provides a full day of clinic each Thursday. We continue to have Chereamie Ramos-Scott, NP provide a half day of clinic on Tuesdays.

FY 2019-20 MHSA PLAN UPDATE
COMMUNITY SERVICES & SUPPORTS (CSS) UPDATE REPORT

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 25

PROVIDER NAME: Oakland-PATH/LifeLong Medical Care

PROGRAM NAME: Behavioral Health - Primary Care Integration Project

Program Description: LifeLong Medical Care operates a Federally Qualified Health Center (FQHC) to provide co-located services at the Oakland Adult Community Support Center (OCSC) operated by ACBH. The project provides coordinated, integrated health care to adults with serious mental illness. The project is called "Promoting Access to Health" (PATH) and has a Wellness Program to provide group health education and encourage socialization.

Target Population: PATH services are offered to all adults (18-59) and older adults (60+) assigned to the service team at the support center.

I. FY 2018-19 Outcomes:

a. **Number of unique consumers/clients served:** 314 clients enrolled in PATH East Oakland
b. **FY 2018-19 Impact:** In our recent monthly debrief, a patient's case manager wanted to express her gratefulness to our program. She is a new case manager and was interviewing one of her patients who had a swollen leg. The case manager reached out to the PATH nurse who was able to triage the patient and get him in to see a clinician the same day. The nurse coordinated a Doppler evaluation and patient was ultimately cleared. The team worked together to care for the patient without a delay in care.

II. Please describe ways that the program strives to:

a. **Reduce mental health stigma:** Our patients are seen in a clinic with their peers, in an environment that they have become accustomed to. Our staff are compassionate and are thoughtful about language used in communication with our clients. Additionally, we work together with the Peer Health Educator to develop programs and groups were patients feel welcomed and safe to share their stories and be themselves without judgement.
b. **Create a welcoming environment:** We allow patients who are scheduled on a given day to see a provider whenever they show up. We understand that locating our clients can be challenging so we accommodate the patient if they show up earlier or later than their scheduled appointments. The PATH program also offers group visits whereby patients are able to contribute to the group as they feel comfortable while learning about basic health topics, mental health tools and group communication.

III. Language Capacity for this program: We currently have two clinicians who speak Spanish. We use the language line for further interpretation for our patients.

IV. FY 2018-19 Additional Information: We have added a Podiatrist to the patient care team at PATH in an effort to give our patients access to a specialist in our already integrated clinic. We have also offered diagnostic testing and health education by our Respiratory therapist to those patients who could benefit from the service.

FY 2019-20 MHSA PLAN UPDATE
COMMUNITY SERVICES & SUPPORTS (CSS) UPDATE REPORT

V. FY 2018-19 Challenges: The usual and continued challenges around transportation and quality housing still exist. We continue to be challenged by getting patients to comply with primary care appointments.

VI. FY 2019-20 Projections of Clients to be Served: We expect at least a 20% increase of patients being served through our Eastmont PATH program.

VII. FY 2019-20 Program or Service Changes: There are no projected changes for the upcoming 2019-20 FY at our Oakland PATH site. However, we expect to open another PATH site at Eden in early October to serve patients in another integrated clinic to service patients in the surrounding community.

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 25

PROVIDER NAME: Alameda County Health Care for the Homeless(ACHCH)/LifeLong Medical Care

PROGRAM NAME: TRUST Clinic Health Center

Program Description: The TRUST Clinic is a multi-service clinic designed to improve the health status of people who are homeless, including providing assistance with housing and income supports.

The TRUST clinic is designed to provide a combination of clinical services and wrap-around non-clinical support services to address the social determinants of health that impact people who are homeless. Comprehensive services include primary care, psychiatric care, individual and group therapy, substance use treatment include Medication Assisted Treatment (e.g. buprenorphine), acupuncture, podiatry, care coordination, health coaching, intensive case management, and support for social determinants of health including housing navigation, disability documentation, and benefits linkage.

The TRUST client population has a high prevalence of trauma, severe mental illness, substance use disorders, and complex and chronic medical conditions. People who are high-utilizers of emergency, inpatient, and crisis health care services are better served in a community based outpatient setting like the TRUST clinic.

Target Population: Homeless, low-income adults, with chronic mental and physical health disabilities and/or clients of an Alameda County Behavioral Health Care service team; and not currently engaged in primary care elsewhere or have would be better served by the integrated primary care at the Trust Clinic.

I. FY 2018-19 Outcomes

a. **Number of unique consumers/clients served:** 1,348 persons served FY18-19
b. **FY 2018-19 Impact:**
   In FY 2018-19, a total number of 1,348 persons were served at ACHCH/Lifelong TRUST Health Center. TRUST patients received a total of 12,798 care visits. Visit types include 4,192 medical visits (physician or nurse practitioner), 2,953 behavioral visits (psychiatrist, psychologist, or LCSW), and 5,228 enabling services visits (case management, health coaching, housing coordination, nursing).

   TRUST health center patients were 34% women and 66% men. The breakdown of race was 61% African American, 22% white, 11%, Latinx, and 6% other. The average patient age was 47 years and ranged from 18 to 88. 93% of patients were experiencing homelessness or housing vulnerability (e.g. doubled up), and 67% were literally homeless (e.g. street or shelter).

II. Please describe ways that the program strives to:

a. **Reduce mental health stigma:** One of the core goals of the clinic from inception has been reducing mental health stigma in primary care settings. As a process outcome, we aim to have each new patient complete a behavioral health intake with a licensed provider (LCSW, psychologist, psychiatrist) within the first month of care. This acknowledges the large proportion of our patients who suffer from severe mental illness, as well as begins to complete a care plan that will link them to necessary services, such as case management. The clinic is a great example of a project sitting on the line of the behavioral and physical health systems and actively works to

link the two. We have regular meetings with behavioral health leadership and case management providers. In addition, we have weekly trainings and case conferences that are focused on the unique needs of this population, such as mental health first aid and trauma-informed care.

b. **Create a welcoming environment:** All people are welcome to come by the Trust Health Center waiting room to learn about services. In our waiting room, we have computers available for use, as well as coffee and bag lunches. We offer drop-in showers for patients of the clinic, as well as have a food pantry one day a week. Our waiting room is staffed by a waiting room manager who is prioritizes checking in with all people in the waiting room to ensure that there are needs are being met. In addition, we have a consumer group known as the "Trust Partners" who meet monthly and provide feedback on services, as well as have implemented two different consumer experience surveys.

III. Language Capacity for this program: Our clinic is equipped to provide direct services in both English and Spanish. We use a language line to provide services to clients who speak other languages.

IV. FY 2018-19 Additional Information:

Referrals Sources: ACHCH/LifeLong TRUST Health Center received new patient referrals from over 40 different community partners in FY18-19. The single highest referral source was word of mouth from other patients, bringing in 39% of new patients. Other leading community referral sources were benefits advocacy partners HAC and BALA (18%), the ACHCH program (8%) and BACS (7%). 35% of patients were referred by over 35 different community providers. Notable numbers of referrals came from needle exchanges, shelters, recovery/transitional programs and other outreach/services providers.

Behavioral Health Diagnoses: Both ACHCH/Lifelong TRUST health center primary care and behavioral health clinicians diagnose and treat patients with very high comorbidity. 52% of patients were treated for depression, 40% had trauma-related disorders (PTSD), and 50% had substance use-related disorders. Top behavioral health diagnoses included depression, PTSD, anxiety, and psychosis. Top substance-related diagnoses included alcohol, opioid, and stimulant use disorders.

Primary Care Diagnoses: Most frequent ACHCH/Lifelong TRUST health center primary care diagnoses are for substance use disorders, musculskeletal pain, mental health, hypertension, heart disease, diabetes, and pain.

Housing Coordination/Referrals: A total of 176 coordinated-entry system applications were completed, with 89 patients being matched to permanent supportive housing through Home Stretch. 94 individuals were referred to additional opportunities, such as Section 8 and affordable housing units. 961 waitlist applications were completed.

Other Health Outcomes: During the year, the clinic established speciality HIV and transgender care care panels. In addition, we continue to have a robust opioid use disorder clinic, where we have 30-50 patients on medication assisted treatment at any point in time. This clinic is the first in the county to offer Sublocade, which is an injectable form of Suboxone, to the safety net.

V. FY 2018-19 Challenges:

The most concerning challenge to the program is the continued explosion of homelessness, with a 42% increase in Alameda County between 2017-2019. We have been highly successful in engaging our clients, however, with increasing homelessness we have a responsibility to our community to continue engaging our current patients, as well as work to engage new patients. This presents difficulties in regard to

staffing, which is not just a question of serving more people but also people with multiple complex conditions developed from living outside for some time. In addition, our physical space is quite small for the number of clients we are serve, so we are pursuing various options to remedy this but none would be a long-term solution to parallel the increased demand for services.

VI. FY 2019-20 Projections of Clients to be Served:

ACHCH and LifeLong Medical Care plan to serve an increasing number of patients in FY19-20, estimating some 1,400 unduplicated patients and some 13,500 visits.

VII. FY 2019-20 Program or Service Changes:

During the 19-20 year, the clinic will now have a street outreach arm which will provide outreach, social, and medical services to encampments in Oakland and work to link the patients back to the Trust Clinic. This will be the 5th year that the clinic has been open. We believe that the depth of care we provide to each client is in large part related to our successes. Because of this, we have begun discussions with LifeLong regarding what the appropriate final number of patients should be and will possibly reach that target in the coming year. If that is the case, ACHCH leadership will be excited to work with others in development of another clinic.

FY 2019-20 MHSA PLAN UPDATE
COMMUNITY SERVICES & SUPPORTS (CSS) UPDATE REPORT

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 26A

PROVIDER NAME: Hiawatha Harris, M.D., Inc./Pathways to Wellness Medication Clinic

PROGRAM NAME: Training and Technical Assistance on Accurate Diagnosis and Appropriate Medication Treatment and Healing Practices for African Americans

Program Description: Hiawatha Harris, M.D., Inc./Pathways to Wellness Medication Clinic designs and delivers culturally responsive services and technical assistance support to help psychiatric prescribers who provide medication assessment and support to African American adults (18-59) living with mental health issues. The culturally responsive curriculum was developed to address the topics of: 1. Stigma around mental health problems in the African American community that can lead to delays in or termination of treatment; 2. Medication issues such as over/under prescribing, incorrect dosage and side effects; 3. Historical trauma of African Americans; 4. Health disparities impacting African American communities; 5. Bias and racial stereotypes; 6. Understanding barriers to accessing mental health services; 7. Knowledge of community holistic interventions such as spiritual, family, and community support; and 8. Strategies for provision of more culturally responsive and congruent services.

Target Population: Alameda County psychiatric prescribers who are identified by ACBH who provide services to adults who identify as African American, ages 18-59 who have moderate to severe mental illness impairments resulting in at least one significant impairment in an important area of life functioning.

I. FY 2018-19 Outcomes:

a. **Number of unique consumers/clients served:** There were a total of 101 (unique) persons in attendance at our four scheduled trainings. However we had a total of 166 persons who were registered for the trainings and for a variety of reasons were unable to attend.
b. **FY 2018-19 Impact:** The training program was able to engage a mix of professional disciplines and we had at least five agencies that attended two or more of the training sessions. These agencies are now in a position to begin to make the needed changes in their organization that will improve the behavioral health services for their African-American client population.

   In one of the trainings the participants had an opportunity to begin to develop an intake form that would be more culturally sensitive for the African-American population. There were also two trainings that offered very specific information regarding prescribing more appropriate medications for use with the African-American population. Overall participants reported knowing more about *how to better serve* this particular population or at minimum learning something new about best practices after leaving our trainings. We received several calls and numerous emails about our trainings and how valuable this service was in Alameda County. We also received requests to come out to individual program sites to assist with the implementation of a number of strategies and techniques presented in our trainings.

II. Please describe ways that the program strives to:

a. **Reduce mental health stigma:** Participants who attended the workshops were given an opportunity to practice developing a more culturally sensitive intake form. They were also cautioned not to use stereotypes and that one of the best ways to understand what the African-

American client would like to see in treatment, would be to "ask" them. We also went over various reasons why the African-American population may elect not to seek behavioral health services.

The program offered providers with information that they could utilize in terms of understanding various reasons why the stigma regarding behavioral health services in African-American communities is often related to the type of care that this population has received historically from behavioral health service providers. Most often they receive their services in overcrowded, understaffed, city, county and state mental hospitals. It was also more likely for an African-American youth or male with a drug problem to be placed in a correctional facility as opposed to being offered behavioral health services that would be more likely offered to the majority population. In assisting the providers in understanding why the stigma in the African-American community exists, they could also utilize this information in order to make their services more welcoming and more appropriate for their African-American population and other cultures.

The attendees in the workshop were given an opportunity to practice developing a more culturally sensitive intake form. They were also cautioned not to use stereotypes and that the one of the best ways to understand what the African-American client would like to see in treatment would actually be to "ask" them.

b. **Create a welcoming environment:** In understanding this area we know that spiritual assistance may be appropriate for some African-Americans however in order to be culturally sensitive we need to find out from a particular client that we are working with, what would make them feel most welcome in there clinic.

III. Language Capacity for this program: Program and training is provided in English but we have two trainers who are bi-lingual (Spanish).

IV. FY 2018-19 Additional Information: The contract is up-to-date on all of its' funding reports and we were able reach all of the activity milestones outlined in the first fiscal year contractual agreement. This calendar year we were able to offer three full days of training and two half days for a total of 32 hours of training in total of 5 five sessions for this new contract.

A pre-and post-test was completed for each of the trainings and the information has been reviewed and has been used to identify FY 2019-2020 training topics and technical assistance needs.

We also now have a website for participants to register for trainings and also to ask specific questions. The website is also being utilized as an opportunity to share pertinent information regarding the African-American population that may be helpful to the behavioral health provider network.

V. FY 2018-19 Challenges: Our primary challenge in the first year of the program was 1. Starting the contract mid- year and having a shorter period to develop the training curriculum. 2. Engaging more prescribers from the behavioral health system. While the program has engaged a mixture of behavioral health personnel we would like to see more prescribers involved in the trainings. We believe that we will be able to increase the prescriber attendance once we have the ability to issue CMEs. This will significantly increase the non-medical staff attendance as well. We will continue to work through the office of BHCSs' Medical Director until we are properly set up with BHCS.

FY 2019-20 MHSA PLAN UPDATE
COMMUNITY SERVICES & SUPPORTS (CSS) UPDATE REPORT

VI. FY 2019-20 Projections of Number of Attendees: We project that we will have 120 – 150 attendees and/or active users next fiscal year. The professionals will utilize a variety of our training methods and will project an increase in the use of our website. For an example, in communicating with past participants, to assist them in developing culturally sensitive tools, and to support them in change of their prescribing practices utilizing the information received in the workshops and trainings from our first year.

VII. FY 2019-20 Program or Service Changes: We will work with the county to have our training programs certified for CME/CEU credits for the licensed health care professionals who attend our trainings.

We will have an increase use of the website to offer technical assistance for specific issues being experienced at specific agencies. For an example, if one agency is experiencing significant issues with African-American youth who are living in areas that are at high risk for trauma and community violence, we would work with them to develop culturally sensitive expertise that will allow them to improve service delivery to this particular population.

Next fiscal year we will shift from offering 6 to 8 hour trainings to offering more trainings now within a 3 to 4 hours training period. We believe it will be more appropriate for the provider groups and will allow us to get more medical staff attendance. This combined with the ability to obtain continuing education units we believe will definitely increase attendance.

In addition, we will focus on moving from theory to practice in allowing participants to have some opportunity doing the training for hands-on experience in terms of developing more culturally sensitive documents for their organization. We have requested additional dollars to support this “Technical Assistance” piece of the contract, which will allow us to conduct trainings as well as provide Technical Assistance in the program settings.

FY 2019-20 MHSA PLAN UPDATE
COMMUNITY SERVICES & SUPPORTS (CSS) UPDATE REPORT

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 26B

PROVIDER NAME: ROOTS

PROGRAM NAME: AfiyaCare

Program Description: AfiyaCare provides mental health services, case management/brokerage and crisis intervention. Services are provided to accomplish the following goals: 1. Help clients to address stressors and enhance their mental and emotional wellbeing; 2. Connect clients immediately to resources to meet urgent and essential needs; 3. Connect clients with short- and long-term support services; and 4. Reduce hospitalization, incarceration, and other emergency services.

Target Population: AfiyaCare serves adults who identify as African American, ages 18-59, with a serious mental illness (SMI), that have a history of involvement with the criminal justice system, which may include individuals previously engaged in mental health crisis, residential, and/or outpatient services.

I. FY 2018-19 Outcomes:

a. **Number of unique consumers/clients served:** 11
b. **FY 2018-19 Impact:** We have found success with gaining eligible AfiyaCare clients through our internal referral system. This has led us to have clients that are already successfully linked to benefits and already in the process of being linked to needed resources, but who need additional support by those trained to address their behavioral concerns as well. Through Prop 47 funds and additional housing resources, our care navigators have been able to help two clients secure housing during our short time implementing AfiyaCare.

<u>Client story:</u> Amr. P is a 48 year old veteran of the Gulf and Afghanistan wars. Mr. P has a mental health diagnosis of PTSD, Generalized Anxiety disorder with psychotic features. Mr. P's story is a tragic one of how the trauma which caused the development of his diagnosis was a result of his service for our country. The client was further traumatized by the military due to the fact they would not acknowledge the part they played in the traumatic event. In addition, Mr. P was further victimized by the fact the military denied his war injury and gave him a less than honorable discharge, which prevented his access to veteran benefit which could put him on the road to health.

Mr. P left the military frustrated, handicapped physically and emotionally and his less than honorable discharge was a barrier to sustained employment. Mr. P suffers from sleep deprivation which was a result of his military conditioning that required him to exist on two hours of sleep a night. To this day has not returned to a normal sleep pattern. Lack of sleep has resulted in symptoms visual and auditory hallucinations. Mr. P developed an anger management problem which led to his incarceration in Billings, Montana. When Mr. P was released he returned to Oakland California and his association with Roots Community health began.

Mr. P's association with Roots Community Health changed his perspective about health care in general and mental health specifically. Mr. P benefited from culturally congruent health navigation services that Roots offers it client many of the navigators have shared life experiences and they are able to instill hope as well as guide the client through barrier removal. Afyia Care clients are educated about health in general and the direct correlation between physical health and mental health. This helps to remove this stigma of accepting mental health services in the African-American community.

Mr. P has attended Anger management classes offered at Roots. The client was directed to the office of Veteran Affairs at Eastmont Mall from one of our health navigators and is now in the process of getting his discharge reviewed and changed to honorable. In speaking with his health navigator Mr. P is an active participant with the supportive services offered.

My relationship with Mr. P as his behavioral health clinician is new since just completed my first month with Roots Community Health. Mr. P was my first client and I have seen him every week at his scheduled appointment on time. On our first session you could tell Mr. P was physically uncomfortable due to the fact he was experiencing muscle spasms in his right arm. The clinic gave him a referral for acupuncture which he hopes will bring him some relief.

After gathering some history we began with some somatic exercises to manage triggers which will precipitate some of his mental health symptoms. Mr. P is exploring themes of time lost with family and re-establishing those connections. Mr. P redirects his energies toward achieving the goals that are set before him now, seeking employment, getting his own apartment and making arrangements to marry his fiancé. Mr. P currently resides with his father and he has been employed at the family church installing sprinkler system and landscaping. In our last session Mr. P had over five job interviews scheduled.

The integrative care approach model used with our AfiyaCare clients from a healing community (Roots) which mirrors the client's experiences within the community at large proves to be beneficial with clients like Mr. P.

II. Please describe ways that the program strives to:

a. **Reduce mental health stigma:** The AfiyaCare Program is striving to reduce mental health stigma by educating clients on the fact that mental health is similar to physical health; whereas we all have it and the impact mental health has on our daily lives. The clinicians in AfiyaCare will be providing individual therapy as well as support groups so that clients will be able to connect and learn from other people who are dealing with the similar issues. AfiyaCare staff actively use person first language so that clients are not defined by the issues that they're facing or their diagnosis.
b. **Create a welcoming environment:** AfiyaCare staff are trained to provide culturally competent care from an Afrocentric perspective. This creates an environment where our African American clients can feel that they are seen, heard, and understood in a context that is relevant to their culture and beliefs. Our peer staff create a welcoming environment because they are able to relate to our clients from personal experience and can make each client feel that they are welcomed and not judged because of their past experiences.

III. Language Capacity for this program: English.

IV. FY 2018-19 Additional Information: Our behavioral health department has diligently been building significant capacity to prepare us to bill specialty mental health within 12 months as required in our contract. We have successfully hired two qualified licensed clinicians, gained a licensed clinician to complete QA tasks and program administrator responsibilities, and included our data administrator to be skilled in the specific data reporting needs. ACBHS staff have also been very helpful in connecting us to necessary county trainings and guiding us on the structure of AfiyaCare processes and procedures.

FY 2019-20 MHSA PLAN UPDATE
COMMUNITY SERVICES & SUPPORTS (CSS) UPDATE REPORT

V. FY 2018-19 Challenges: An ongoing challenge has been that we have not had access to needed systems (Clinician Gateway and INSYST) and the infrequency of required trainings before AfiyaCare was implemented. This has caused us to have late documentation entries in Clinician's Gateway, inability to open clients in INSYST at start of service, and having a delay in completing needed paperwork, data entry, and documentation that have to be done in a certain order, within certain timelines. Due to completing INSYST training after AfiyaCare was implemented we were unable to open clients in INSYST until July 2019. We are currently working closely with ACBHS staff about our concerns, questions, and updates throughout this transition.

VI. FY 2019-20 Projections of Clients to be Served: 40

VII. FY 2019-20 Program or Service Changes: None

FY 2019-20 MHSA PLAN UPDATE
COMMUNITY SERVICES & SUPPORTS (CSS) UPDATE REPORT

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 26C

PROVIDER NAME: Pending

PROGRAM NAME: MH Wellness Supports at MHSA Housing sites

Program Description: Culturally Responsive MH supports and activities for residents living in MHSA funded housing sites.

Target Population: Residents living in MHSA funded housing sites throughout Alameda County.

Progress to Date: This project is pending. There are discussions happening in regards to having these supports and activities implemented by the ACBH housing team or engaging in a public procurement process. More information will be shared when decisions are finalized.

FY 2019-20 MHSA PLAN UPDATE
COMMUNITY SERVICES & SUPPORTS (CSS) UPDATE REPORT

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 27

PROVIDER NAME: ABODE Services

PROGRAM NAME: In-Home Outreach Team (IHOT)

Program Description: The In-Home Outreach Team (IHOT) provides outreach and engagement services to adults with untreated mental illness, with the intention of connecting them with psychiatric care and other community supports. Each IHOT team consists of: a clinical lead, a licensed eligible clinician, two peer advocates, and one family advocate enabling them to have multiple and varied perspectives with which to relate to the participants and their families. This unique factor helps with finding new ways to engage folks otherwise considered resistant or reluctant to engage in mental health services. IHOT visits participants in their homes, hospitals, jails, and in the community to encourage them to engage in mental health treatment. Their goal is to reduce the impact of untreated mental illness in these adults and provide support or their families. The intention of referral and linkage is to help prevent an increase in symptoms, added impairments, or need for more hospitalizations. The team's schedules appointments with participants, family members, friends, and other providers, as well as assists with connections to community resources.

Target Population: IHOT serves adults (age 25+) with severe mental illness, who are not currently engaged in mental health treatment or have become disengaged, who are considered resistant or reluctant to participating voluntarily and present with a variety of barriers that prevent them from connecting to mental health services and other community resources. IHOT serves adults throughout Alameda County; STARS TAY IHOT Program focuses on transitional age youth (TAY) ages 16-24 years old, throughout Alameda County.

I. FY 2018-19 Outcomes:

a. **Number of unique consumers/clients served:** Over FY 18/19 (July 2018-June 2019) Abode IHOT served 113 clients. Twenty-three of those clients are still being served by our team.
b. **FY 2018-19 Impact:** For FY18/19, 41 of the 90 (# of clients closed out of 113) clients were referred to other programs ranging from FSP, private MH, case management, drug/substance abuse and Psychiatric SNF. Another 41 were referred to some other programs (ie shelters, Wellness Centers, etc). Unfortunately, the exact referral was not clear, however, they were connected to services in some way. The remaining 8 clients were referred to AOT and BH Court.

   100% of families engaged with IHOT services were connected to resources such as FERC and NAMI. We have connected family members to NAMI groups whose primary language is not English and provided information in other languages such as Cantonese, Spanish and Vietnamese. In addition to FERC and NAMI, our family advocate runs a support group specifically for family members. Our family support group has been running monthly for approximately 1 year and has an average attendance of 5 family members. We have seen the group grow to as many as 10 family members present for support and are hopeful this will continue to grow into the future fiscal year.

We have worked with many family members and the following is a small example of how our team has helped a family navigate an often overwhelming system: "I am so grateful that Katy and the other IHOT team members were able to support me. I was supported with all doctor visits. I was given books to read/learn more about schizophrenia. All of the advocates were sincere and cared about my welfare and my fathers. If it weren't for Katy and the other advocates, I would have missed a lot of work and possibly been out of a job. They were all my guardian angels." This is a statement from one of our family members. Her father is our client and after his unexpected release from John George our team has worked tirelessly to ensure he is connected to resources (medical and mental health) for continued monitoring and medication as well as maintaining his current housing. This client has a history of losing housing due to increased behaviors when he is not medication compliant. The team provided invaluable support to the daughter and allowed her the flexibility and comfort of knowing her father was being taken care of.

We do not track client hospitalizations within our own data system however, providing clients with a line of communication to someone who is advocating for them and educating involved family members about community resources and mental health, we have seen a decrease in the use of crisis or emergency services over the time we are involved with the client and/or family. Our team makes every attempt to outreach to our clients and families on a weekly basis. Sometimes this is in the form of a phone call and other times it is face to face. Often our staff will assist the family/support network at the initial and follow up appointments to make certain clients are engaged in the treatment process as well as following our contractual obligations.

II. Please describe ways that the program strives to:

a. **Reduce mental health stigma:** Through the design of the IHOT team we are able to work diligently at reducing the stigma associated with mental health. As stated above, our team consists of peer specialists and a family advocate who are charged specifically to support participants and family members in understanding mental health needs and helping them navigate an often times overwhelming system. Our peers are able to model mental wellness and use their story of recovery as a person with lived experience to help reduce mental health stigma. The family advocate can uniquely understand and empathize with the struggles a family member or loved one supporting a person with acute mental health symptoms.

   Our agency focuses on harm reduction and strengths based case management, all of which aid to our team in being successful at reducing the stigma of mental health in society.

   Staff participate in normalizing activities with participants like meeting for coffee, having lunch, taking a walk at the lake, etc.

   Participant centered language is used in morning meetings and treatment planning focuses on participants' needs and strengths. Services are individually tailored to meet the needs of each participant.

b. **Create a welcoming environment:** Our team strives to make a connection with both clients and family members. The most effective way we have found to do this that creates a sense of empathy and welcome, is to meet people where they are at. For some that's just a meal. For others that means they are willing to acknowledge they need help.

FY 2019-20 MHSA PLAN UPDATE
COMMUNITY SERVICES & SUPPORTS (CSS) UPDATE REPORT

We have created a welcoming space for in our reception area. Participants are able to come and access clothes, food, water, computers, and immediate access to a staff.

III. Language Capacity for this program: As an agency, we utilize the language line in order to reach out to as many clients/family members as we can regardless of what they identify as their primary language. We have not encountered any major language barriers at this time.

IV. FY 2018-19 Additional Information: It was noticed during the collection of this report that some valuable data/information was missing (i.e. exact referrals). We have since implemented more data tracking in our own records to assist in having the most accurate information.

V. FY 2018-19 Challenges: Working on an IHOT team is difficult. We as a team have dealt with staffing challenges during this last fiscal year, however, we utilized those times as learning experiences and made efforts to streamline our processes to be more efficient in our service delivery. Hiring and maintaining clinical staff still remain a huge challenge. Barriers include inability for our agency to meet county salaries or other offers, stress from working with a population with high acuity, and the general shortage of social workers.

VI. FY 2019-20 Projections of Clients to be Served: Over FY 2019-20 our goal is to serve at least 50 clients. We will aim to serve 25-30 clients at any given point in time.

VII. FY 2019-20 Program or Service Changes: None

FY 2019-20 MHSA PLAN UPDATE
COMMUNITY SERVICES & SUPPORTS (CSS) UPDATE REPORT

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 27

PROVIDER NAME: Bonita House

PROGRAM NAME: In-Home Outreach Team (IHOT)

Program Description: The In-Home Outreach Team (IHOT) provides outreach and engagement services to adults with untreated mental illness, with the intention of connecting them with psychiatric care and other community supports. Each IHOT team consists of: a clinical lead, a licensed eligible clinician, two peer advocates, and one family advocate enabling them to have multiple and varied perspectives with which to relate to the participants and their families. This unique factor helps with finding new ways to engage folks otherwise considered resistant or reluctant to engaging in mental health services. IHOT visits participants in their home, hospitals, jails, and in the community to encourage them to engage in mental health treatment. Their goal is to reduce the impact of untreated mental illness in these adults and provide support or their families. The intention of referral and linkage is to help prevent an increase in symptoms, added impairments, or need for more hospitalizations. The teams schedule appointments with participants, family members, friends, and other providers, as well as assist with connections to community resources.

Target Population: IHOT serves adults (ages 18-59) with severe mental illness, who are not currently engaged in mental health treatment or have become disengaged, who are considered resistant or reluctant to participating voluntarily and present with a variety of barriers that prevent them from connecting to mental health services and other community resources. IHOT serves adults throughout Alameda County; STARS TAY IHOT Program focuses on transitional age youth (TAY) ages 16-24 years old, throughout Alameda County.

I. FY 2018-19 Outcomes:

a. **Number of unique consumers/clients served**: 90 (Target: ≥ 50)
b. **FY 2018-19 Impact**: At least 62 percent of engaged clients were successfully linked to outpatient mental health services or rehabilitation and recovery services within the first 12 months of referral (Target = ≥ 50%). 88 percent of engaged clients experienced a decrease in access to crisis stabilization, psychiatric health facility, or psychiatric hospitalization within their first 12 months of entry in to the program.

Client story: *For confidentiality purposes pseudo initials are used in story below.
SJ is a 30y/o Asian- American male with history of suicide attempts, with history of inconsistently taking medications, reluctant to engage with clinicians, disengaged with friends, family and the community. SJ viewed his family as the enemy and threatened to harm his family after a suicide attempt which included him placing a belt around his neck in front of his mother, and threatening to harm his family. The family packed up and moved into a hotel for 8 months because they felt unsafe in their house. The barriers were that the mother didn't want SJ to "hate" her. The IHOT family coach encouraged the family to attend her weekly family support group where they were coached in healthy tools to break their fears of returning home. The IHOT team worked with the family to enter the house, to approach SJ who had barricaded himself in the family home and had decompensated to the point of needing hospitalization. Through the family attending the weekly meetings, and its engagement with the IHOT

team, SJ agreed to open the door. With the help of the Mobile Crisis Team, Alameda Police, and the Bonita House IHOT team, SJ surrendered after 7 hours, and the family was able to return home again.

II. Please describe ways that the program strives to:

a. **Reduce mental health stigma:** Inclusive and non-judgmental, avoiding clinical language (jargon), linkages to community (e.g., homeless encampments, inpatient settings) and natural supports (e.g., family, friends), staff cultural awareness and competency.
b. **Create a welcoming environment**: Empathic, strong use of Motivational Interviewing, collaboration with natural supports.

III. Language Capacity for this program: English explicit at this time. Looking at budget for bi-lingual staff, and/or use of Language Line. To date, language needs have been satisfactorily addressed.

IV. FY 2018-19 Additional Information: None

V. FY 2018-19 Challenges: English explicit at this time. Looking at budget for bi-lingual staff, and/or use of Language Line. To date, language needs have been satisfactorily addressed**.**

VI. FY 2019-20 Projections of Clients to be Served: Exceed FY 18-19 enrollment of 100-120 clients by a minimum of 15% (115 – 118).

VII. FY 2019-20 Program or Service Changes: Cleo Thompson became the Interim Program Lead January 2019.

FY 2019-20 MHSA PLAN UPDATE
COMMUNITY SERVICES & SUPPORTS (CSS) UPDATE REPORT

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 27

PROVIDER NAME: La Familia

PROGRAM NAME: In-Home Outreach Team (IHOT)

Program Description: The In-Home Outreach Team (IHOT) provides outreach and engagement services to adults with untreated mental illness, with the intention of connecting them with psychiatric care and other community supports. Each IHOT team consists of: a clinical lead, a licensed eligible clinician, two peer advocates, and one family advocate enabling them to have multiple and varied perspectives with which to relate to the participants and their families. This unique factor helps with finding new ways to engage folks otherwise considered resistant or reluctant to engaging in mental health services. IHOT visits participants in their home, hospitals, jails, and in the community to encourage them to engage in mental health treatment. Their goal is to reduce the impact of untreated mental illness in these adults and provide support for their families. The intention of referral and linkage is to help prevent an increase in symptoms, added impairments, or need for more hospitalizations. The teams schedule appointments with participants, family members, friends, and other providers, as well as assist with connections to community resources.

Target Population: IHOT serves adults (ages 18-59) with severe mental illness, who are not currently engaged in mental health treatment or have become disengaged, who are considered resistant or reluctant to participating voluntarily and present with a variety of barriers that prevent them from connecting to mental health services and other community resources. IHOT serves adults throughout Alameda County; STARS TAY IHOT Program focuses on transitional age youth (TAY) ages 16-24 years old, throughout Alameda County.

I. FY 2018-19 Outcomes:

a. **Number of unique consumers/clients served:** 93 Total Clients Served
b. **FY 2018/19 Impact:** A substantial percentage of La Familia IHOT clientele were linked to specialty mental health services within Alameda County Behavioral Health, including, Level 1 Service Teams, Full Service Partnerships, Felton Institute, and Assisted Outpatient Treatment. Furthermore, this clientele was referred and linked to supplemental services and basic needs, such as General Assistance, Social Security Income, legal services regarding housing and other areas of need, homeless shelters, and residential care facilities. This clientele was able to enroll in clinical case management and psychiatric services, and access medication management for an initial episode or resume treatment after a long period of inaccessibility or refusal of services. La Familia IHOT has been able to accompany clientele through various transitions, interpersonal and institutional, including, but not limited to, substance abuse treatment and sobriety from chemical dependence; mental health stabilization and mental health treatment from psychiatric hospitalization; stable temporary or long-term housing from homelessness; a return into the community from short periods of incarceration; family stability and community integration from severe isolation and family conflict. La Familia IHOT consistently provides psycho-education to family members regarding mental illness. Families also receive consistent coaching regarding how to navigate the vast array of services within Alameda County Behavioral Health. IHOT has also supported community members who refer clients to IHOT in very similar ways as family members.

Client Story: La Familia IHOT worked with a homeless 56 year-old Caucasian male with a history of eight psychiatric hospitalizations in 2018; physical disability and mobility issues; as well as challenges with emotional regulation, depressed mood, and self-harming behaviors. IHOT was able to admit the client into a long-term homeless shelter operated by Building Opportunities for Self-Sufficiency. IHOT was also able to enroll the client in a payee service with Building Opportunities for Self- Sufficiency. Over the course of services, it became suspected that a family member was abusing the client financially and IHOT collaborated closely with Adult Protective Services (APS) to address and stop the abuse. IHOT also supported the client by assisting him to obtain basic necessities, such as clothes and other household products. IHOT also transported the client to numerous medical appointments as well as enroll him in a medical clinic. IHOT requested a Level I Service Team program but the client was found ineligible for this level of care due to a Traumatic Brain Injury. Therefore, IHOT collaborated with APS and enrolled the client in the Felton Institute, Case Management for Older Adults with Disabilities.

II. Please describe ways that the program strives to:

a. **Reduce mental health stigma:** La Familia IHOT employs various strategies to reduce mental health stigma. Firstly, all of our staff are people of color and the majority of our staff speak Spanish. La Familia IHOT staff share a common cultural community and fluency in language with the majority of our clientele. This shared cultural community and language proficiency disrupts stigma in almost unspeakable ways which would not be as effective if these same clients and family members would be receiving services from professionals belonging to the mainstream culture. We create a safe space within the lives of clients and their respective families and communities wherein we speak of mental illness as not a personal failure on the part of clients nor the family, nor as a personal or community failure to integrate into the mainstream culture. We also normalize the prevalence of mental illness as a psychiatric disorder and continually draw upon analogies of psychiatric disability to physical illness or medical disability. For example, we encourage our clientele to continue to consume psychiatric medication for their mental illness just as a person with diabetes would need to consume their insulin. We also normalize the symptoms of mental illness as normal responses to childhood trauma and trauma experienced as an adult.

b. **Create a welcoming environment:** La Familia IHOT employs various strategies to create a welcoming environment, in addition to having staff who resemble our clients in cultural and linguistic ways. A majority of La Familia's IHOT clientele are in the pre-contemplative and denial stage of their mental illness or chemical dependence. Our clients have been actively denying their mental illness for several years and disengaged from treatment for substantial periods of time. As a result of this, La Familia IHOT employs a critical strategy of, more often times than not, declining to speak of mental health treatment in the initial stage of outreach and engagement except as a general explanation of scope of services. Instead, we engage clientele by creating safe space where they can verbalize their own goals, goals often times not prioritized by family members and other professionals. As we build a therapeutic alliance with clients, we begin to gradually address symptoms of their mental illness as they express their impairment. La Familia IHOT then addresses internal barriers to accessing the contemplative stage of change, such as shame and embarrassment that comes from being stigmatized for their symptoms.

FY 2019-20 MHSA PLAN UPDATE
COMMUNITY SERVICES & SUPPORTS (CSS) UPDATE REPORT

III. Language Capacity for this program: Three (3) of our five (5) La Familia IHOT staff speak fluent Spanish.

IV. FY 2018-19 Additional Information: We observe three (3) trends in the mental health field that serve as a barrier for program implementation: increasing prevalence of older adult clients, gaps in levels of service, and private insurance providers being unresponsive to client's needs. See the next section for an elaboration on these trends.

V. FY 2018-19 Challenges: We observed three (3) main challenges:
The first trend is an increasing prevalence of older adults (ages 52 – 62) who are socially isolated and homeless. These older adults manifest symptoms which severely impact their ability to seek supportive services and maintain self-sufficiency, and yet they are also not old enough to meet the criteria to receive services from the Older Adult Division of Alameda County Behavioral Health.

The second trend we observed is the inequitable discrepancy between how ACBH considers the level of self-sufficiency that a person with mental illness is supposed to seek and maintain their engagement in services vs. the manifestation of this actualization. For example, we have worked with numerous clients on the moderate to severe continuum of symptoms of mental illness who do not meet the criteria for Level 1 Service Teams, but who are also not self-sufficient enough to seek services on their own from Level 3 Providers.

The third trend we observed is the gap in capacity and commitment to offer services to people who possess private insurance, or at-risk of losing private insurance. We have engaged numerous clients who possess private insurance, however their private insurance provider does not possess the capacity or commitment to provide the level of services the client needs.

VI. FY 2019-20 Projections of Clients to be Served: 90 Clients Projected

VII. FY 2019-20 Program or Service Changes: La Familia IHOT will be hiring a new full-time (FTE) clinician.

FY 2019-20 MHSA PLAN UPDATE
COMMUNITY SERVICES & SUPPORTS (CSS) UPDATE REPORT

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 27

PROVIDER NAME: STARS

PROGRAM NAME: In-Home Outreach Team (IHOT)

Program Description: The In-Home Outreach Team (IHOT) provides outreach and engagement services to adults with untreated mental illness, with the intention of connecting them with psychiatric care and other community supports. Each IHOT team consists of: a clinical lead, a licensed eligible clinician, two peer advocates, and one family advocate enabling them to have multiple and varied perspectives with which to relate to the participants and their families. This unique factor helps with finding new ways to engage folks otherwise considered resistant or reluctant to engaging in mental health services. IHOT visits participants in their home, hospitals, jails, and in the community to encourage them to engage in mental health treatment. Their goal is to reduce the impact of untreated mental illness in these adults and provide support or their families. The intention of referral and linkage is to help prevent an increase in symptoms, added impairments, or need for more hospitalizations. The teams schedule appointments with participants, family members, friends, and other providers, as well as assist with connections to community resources.

Target Population: IHOT serves adults (ages 18-59) with severe mental illness, who are not currently engaged in mental health treatment or have become disengaged, who are considered resistant or reluctant to participating voluntarily and present with a variety of barriers that prevent them from connecting to mental health services and other community resources. IHOT serves adults throughout Alameda County; STARS TAY IHOT Program focuses on transitional age youth (TAY) ages 16-24 years old, throughout Alameda County.

I. FY 2018-19 Outcomes:

a. **Number of unique consumers/clients served:** 52
b. **FY 2018-19 Impact:** Out of 52 clients served during the fiscal year, 22 clients were able to be relinked to a previous provider or linked to a provider when they had not had any services previously.

   The IHOT team was able to provide informational overviews to several different agencies including WestCoast Children's Clinic, Fred Finch STAY and Fred Finch Transitions, as well as TriCity and Covenant House. The IHOT team created connection for collaboration with the YEAH shelter and Covenant House. The IHOT team was able to provide a training as a team for the CASRA conference this year on how to do outreach and connect individuals to care.

II. Please describe ways that the program strives to:

a. Reduce mental health stigma: The program works to meet clients where they are at with the support of transition facilitators and family advocates who have personal lived experience with mental health, substance use, and / or previous homelessness. Having individuals on the team with lived experience supports to put forward the idea that there is not a "better than" or "less than" dynamic. Only individuals who find themselves in times in their lives where they may be struggling more and may need more support to achieve their goals.

b. Create a welcoming environment: The team meets with the individuals they are working with in a caring and non-clinical manner to assist in gaining their trust and to promote a connection. The team utilizes a variety of methods to engage individuals that they are trying to connect with in order to make them feel more comfortable. These methods include games, art, food, and activities such as going to libraries or small walks. The team always seeks to connect with the individuals they are working with in a respectful manner and use the goals that the individual is interested in to help them see the benefit of connecting with other treatment providers. The team expresses interest in the topics and goals that the individual has expressed are important to them. The team will also work with other people that the individual has identified as important supports, once permission is given to include them.

III. Language Capacity for this program: English / Punjabi / Turkish

IV. FY 2018-19 Additional Information: Please see the attached RAS IHOT report

V. FY 2018-19 Challenges: Some individuals may benefit from changing their insurance providers to Medi-Cal. The current model has IHOT meeting with these individuals once or twice only to suggest a switch to Alameda Medi-Cal. However, some individuals may not be in a state to comprehend what the IHOT team may be suggesting due to decompensation. Or they may feel to anxious and untrusting to sit down with the IHOT team to hear about potential benefits to change their insurance. Other difficulties are when clients who are in a decompensated state commit an act that causes them to be arrested. The IHOT team cannot connect with them in jail, as it has been deemed that jail is a location that is a lockout for IHOT services. However, they may still need that support to assist them with being willing to be linked to a provider. When the individual is released form jail, they may become quickly difficult to locate again.

VI. FY 2019-20 Projections of Clients to be Served: 64

VII. FY 2019-20 Program or Service Changes: The team plans to continue to partner well with existing organizations in Alameda County and work to connect well with the individual service providers in those agency settings. The team may reach out to service providers if there is space on the client list to see if anyone would like more assistance with linking their clients back to the mental health or other service provider. The team will continue to provide once monthly family support groups for family members of individuals referred to IHOT.

FY 2019-20 MHSA PLAN UPDATE
COMMUNITY SERVICES & SUPPORTS (CSS) UPDATE REPORT

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 28

PROVIDER NAME: BACS

PROGRAM NAME: Success At Generating Empowerment (SAGE)

Program Description: The Success At Generating Empowerment (SAGE) Program is designed to serve individuals who are in the process of obtaining Social Security Income (SSI) for their qualifying behavioral health (and other disabilities) and who need ongoing clinical care coordination and support as they navigate the challenging bureaucracy while they are managing symptoms related to a behavioral health disorder. Individuals receive assessment, person-centered treatment planning, and ongoing counseling, clinical care coordination, linkage, and peer support. As individuals are awarded SSI benefits, they become stable and effective at managing their own lives. Individuals are then linked with ongoing natural and community-based supports for ongoing support. The program has a multidisciplinary staffing model that includes 50% clinical care coordinators and 50% peer counselors- people with their own lived experiences that can walk alongside someone to navigate the challenges of the system.

Target Population: SAGE serves adults (ages 18-59) and older adults (60+) who have a qualifying behavioral health diagnosis and are in the process of obtaining SSI benefits through local legal advocacy firms, Homeless Advocacy Center (HAC) and Bay Area Legal Aid (BALA). All participants live in extreme poverty, at or are under 10% Area Median Income (AMI). Many individuals are exiting jails or hospitals. The majority of individuals are homeless.

I. FY 2018-19 Outcomes:

a. **Number of unique consumers/clients served:** 410
b. **FY 2018-19 Impact:** The SAGE program addresses mental health barriers and supports client to medical and mental health appointments that aid the client in building their SSI case. SAGE allows clients to build skills that support linkages to the community that will aid the client in being able to maintain connections with providers after they receive their SSI and their time with SAGE is complete. SAGE also works clients in identifying and the barriers their mental health symptoms create in their life and work on enabling the client to build skills that will address those barriers. SAGE also provides advocacy letters that highlight the client's specific struggles and how those struggles impact the client's ability to meet their needs. This work has enabled clients to become more independent and learn how to navigate their specific challenges in a more adaptive way. This has helped clients to maintain connections with providers and the client's support system and to maintain housing by addressing the issues that had led to displacements previously. One such client that SAGE has worked with for the last year was living on the street. The client was unable to stay engaged with his legal advocate, providers and his case manager. The client could not be found when important appointments came up for him and would never respond to the case managers' outreach, only leaving sporadic voicemails in the middle of the night. The client was going to PES at least monthly and had a significant amount of substance use. Recently, we were able to temporarily house him in a hotel so that we could get him to important medical appointments and so that he could recover from minor surgery. This aided us in being able to find

him consistently and work on addressing his specific barriers with him. The client has made all of his appointments, stopped all use, and addressed previous housing barriers that enabled him to get a permanent housing opportunity.

II. Please describe ways that the program strives to:

a. **Reduce mental health stigma:** BACS hires a peer and family partner workforce that ensures that mental health stigma is eradicated from its service delivery system. BACS partners with NAMI, FERC, POCC, and Office of Consumer Empowerment to fight and eradicate the stigma associated with mental illness.
b. **Create a welcoming environment:** BACS utilizes the Welcoming Toolkit that was created by BHCS over five years ago and has an in-house design team to ensure all program locations are welcoming, warm, vibrant, colorful, culturally inclusive, and responsive as well as accessible. BACS has consumer councils for the decorating of the centers. All sites and locations ensure that money is spent on keeping the facilities modern, warm, and inclusive. Additionally, Lavender Seniors certified BACS's sites as LGBTQ inclusive.

III. Language Capacity for this program: English, Spanish. Additionally, BACS access to all threshold languages in-house through BACS' bilingual pool of on-call staff.

IV. FY 2018-19 Additional Information: SAGE has been able to reduce discharges due to non-engagement and increase discharges due to the goal of recieving SSI being met.

V. FY 2018-19 Challenges: Locating clients that have a long history of non-engagement.

VI. FY 2019-20 Projections of Clients to be Served: 540

VII. FY 2019-20 Program or Service Changes: None

FY 2019-20 MHSA PLAN UPDATE
COMMUNITY SERVICES & SUPPORTS (CSS) UPDATE REPORT

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 29

PROVIDER NAME: The Felton Institute

PROGRAM NAME: Older Adult Service Team

Program Description: The Older Adult Service Team (OAST) is a specialized, multidisciplinary mental health program for aging adults with serious mental illness, the first of its kind in the county. OAST is part of the Felton Institute's Senior Division continuum of care model for mental health treatment and services for aging adults. Significant to this model is providing services across the silos of mental health and aging services.

OAST's objective is to improvide the lives of older adults living with the comorbidity of mental illness and health conditions, as well as substance abuse. We provide clinical case managemet support and that promotes our community to age in place and maintian as much autonomy and community involvement as possible.

Target Population: The Older Adult Service Team serves older adults (age 60+) who are living with severe mental illness impairments resulting in at least significant impairments in important areas of life functioning.

I. FY 2018-19 Outcomes:

a. **Number of unique consumers/clients served:** 96
b. **FY 2018-19 Impact:** Our specialized program has connected clients with key resources in the community. As our program has evolved and we've worked with more clients, we have developed structure and procedures to match the unique needs of each client, each new client's needs and strengths informing the next. OAST client care is intense, frequent and our clients require significant support around connecting with medical care, maintaining their housing and ensuring collaboration occurs between the many providers who work with our clients. Unlike other people in the ACBH system of care, OAST clients often have 8+ providers working with them. We are often the conduit that ensures these linkages between providers occur and there is greater opportunity for collaboration.

   Client Story: Mr. S. is a 68 year old white male living with ongoing symptoms associated with Schizophrenia. He frequently responds to internal stimuli and reports command auditory hallucinations and presents with disorganized and delusional thought patterns. He has a history of tobacco, alcohol and marijuana use and a distant history of experimenting with hallucinogens and marijuana at the time of his first psychotic break at age 22. Prior to being connected with our program, Mr. S. was receiving services through a service team for adults living with severe mental illness. Mr. S. loves music and has a wonderful historical knowledge of San Leandro history. Our providers enjoy working with him because he has a beautiful singing voice and plays the guitar quite well and when accompanying him to appointments, he reflects on historical nuances and locations in San Leandro and Oakland. He is compassionate and seeks to contribute in the community.

When he first was referred to our program, Mr. S. had recently been attacked at the Independent Living Home where he was living and was hospitalized with significant stab injuries to his back incurred while he was being robbed by other residents of the ILH. Mr. S. lives also with numerous chronic medical conditions, including emphysema, COPD, hypertension, cancer and Hep C.

Mr. S's functional impairments associated with his mental health challenges include maintaining housing, accessing medical care and community involvement.
He misses appointments and requires significant support advocating for himself with medical providers due to the impact of mental health symptoms and cognitive challenges associated with aging. He has a pattern of eviction from Board and Care residences due to his refusing to follow house rules and smoking in bed. He can become verbally aggressive and has some insight into the intersection of his anger with his ongoing physical pain and challenges with mental health symptoms.

Mr. S. receives supports from our program, and currently requires weekly support from clinical and peer staff. He is currently being evicted from his licensed board and care and additionally receives support through the HSP program. Our primary foci with him at present are connecting him with a new housing resource and supporting him in accessing eye surgery and smoking cessation resources. We anticipate he will require emergency medical care in the near future due to the ongoing issues with his continuing to smoke and symptoms associated with COPD and emphysema.

II. Please describe ways that the program strives to:

a. **Reduce mental health stigma:** Providers at OAST conduct our work utilizing evidence-based frameworks to assess and treat clientele, including harm reduction, trauma-informed care, restorative justice, motivational interviewing, CBT and others. We use a highly collaborative approach (reminiscent of an ACT model but not to fidelity), both internally as a team and in collaboration with external partners.

   Our alliances with providers outside of the mental health spectrum of care have yielded great opportunities in reducing stigma around mental health. From providing education to medical providers and police to supporting family members who have stuck by their loved ones in the face of ongoing, lifelong marginalization and systemic oppression, we provide a platform for clients, their loved ones and providers to collaborate in ways that challenge stigma and discrimination associated with mental illness.

b. **Create a welcoming environment:** OAST has specific procedures designed to ensure clients, families and fellow providers feel welcomed to the office, to each session and connected with the program. Whenever a client visits our office, they are welcomed by our administrator, providers, psychiatric provider and program director; and are offered a snack or small meal. Clients do not wait more than 10 minutes to visit with our psychiatrist and our lively, warm and welcoming office is a departure from typical medical environments. Accessibility is critical to our program's success and part of every dialog about client care. We educate the community including key stakeholders, organizational partners and fellow providers about our program, and the unique issues our clients face.

III. Language Capacity for this program: Our clinicians provide services in Spanish, Vietnamese, Cantonese, French and English.

IV. FY 2018-19 Additional Information: Systemic changes within Alameda County create emerging needs for our clients. Variables and challenges unique to the Bay Area around housing and homelessness are amplified in marginalized communities, specifically older adults and those living with severe mental illness. Our clients have signficiant challenges maintaining their housing, often due to circumstances far beyond their control. Skilled Nursing Facilities have attempted or been succesful in moving clients who cannot pay increased fees. Licensed Board and Care Facilities have transitioned to being Independent Living Homes, reducing the level of care and oversight provided. This is most difficult for our clients who have long histories of homelessness and were at some point in their care connected with housing support through FSP programs. Any shift in housing is a trigger to past trauma associated with homelessness and requires a noteable increase risk assessment and care

Other trends we have observe involved the critical importance of establishing a continuum of care. Our clients often have many providers and coordination of care requires consistent treatment team discussion. Educating different providers about our services and building those relationships has yielded positive results for our clients, increasing their quality of support.

V. FY 2018-19 Challenges: *Accessibility and Efficiency*: Many of the resources we are working to connect our clients with are challenging to access. Whether clients are challenged by mobility issues, strained systems and bureaucracy, each attempt to connect clients with different services from food stamps to IHSS to primary care, is more challenging for the aging adults in our program.

Frequency of Services: While our program is considered a Level 1 Service Team we find that we meet with most of our clients weekly and sometimes more. OAST received many clients during the transition of FSP programs and many of our clients continue to require FSP-level care.
Advocacy and Accompaniment: Most of our clients have emerging or ongoing challenges associated with mobility. They do not take the bus and require support with assisted transportation services like paratransit. We accompany our clients to most of their appointments, supporting them to communicate with different providers.

Housing Crisis: As mentioned before, the Bay Area housing crisis provides challenges to our clients. We are in very close alliance with Board and Care and Independent Living Home managers and our clients' housing is often in flux.

Crisis Services: Several clients (approx. 4) have cycled through emergency and inpatient psychiatric services multiple times since connecting with our program. These clients, in particular, would benefit from inpatient care at Morton Bakar Center. The process and communication associated with this linkage has been incredibly challenging – resulting in breakage of rapport with clients due to systemic challenges and miscommunication between systems of care. We hope that the communication challenges between inpatient and emergency psychiatric support with the service teams and other providers is addressed and resolved with support from ACBHS.

Undetected/Emerging Needs: As our clients age, physical and mental health issues emerge and evolve. We seek additional resources around cognitive changes with clients – many of our clients are dealing

with emerging or fully diagnosed Alzheimer's and/or Dementia diagnoses. We are also often connecting our clients with specific providers to ensure consistent and quality medical care.

Rate Changes: OAST provides significant case management support; the majority of our billing focuses on brokerage, followed by rehabilitation. In order for our program to continue to succeed and expand, we ask for our rates to reflect the work being done. If we are to expand we request a review of our rates in order to sustain our team.

VI. FY 2019-20 Projections of Clients to be Served: OAST hopes to expand our program and serve up to 150 clients in FY 19-20.

VII. FY 2019-20 Program or Service Changes: We are looking forward to expanding our program and welcoming more clients into our program. We have been introduced to billing changes and emphasize that our program is focused on case management and connecting our clients to sustainable resources. We hope to be able to provide excellent services by reducing the caseload to case manager ratio and continue to creatively connect with resources outside of the system of care to ensure our clients' needs are met, particularly around transportation.

For staffing our expansion we seek to connect with more clinical case managers and peer supports and psychiatric care. Our peer supports are essential to creating a specific connection with our clients and we hope to welcome and cultivate a strong peer support program specifically for peers interested in working with older adults.

FY 2019-20 MHSA PLAN UPDATE
COMMUNITY SERVICES & SUPPORTS (CSS) UPDATE REPORT

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 30

PROVIDER NAME: La Familia Counseling Services

PROGRAM NAME: Sally's Place Peer Respite

Program Description: Sally's Place is a Peer Respite Home and is the first and only of its kind in Alameda County. It is staffed by peers, in alignment with the objectives of our local agencies- Pool of Consumer Champions (POCC) and the Alameda County Accelerated Peer Specialist Program (ACAPS). Guests receive support from compassionate peer staff and can stay for up to 14 days. Sally's Place Peer Respite is a voluntary, short-term program that provides non-clinical crisis support to help people find new understanding and ways to move forward with their recovery. It operates 24 hours per day in a homelike environment.

Target Population: Sally's Place serves adults, 18 years of age or older, who are experiencing mental health concerns or distress, have an identified place to stay in Alameda County at the time of intake (which could include a shelter), are able to manage medical needs independently and who voluntarily agree to engage in services.

I. FY 2018-19 Outcomes:

a. **Number of unique consumers/clients served:** Sally's Place Peer Respite open house was on January 9,2019 and we opened for services on January 21, 2019 during FY 2018-19 Sally's Place has provided Peer support Services to 70 unduplicated new guests and re-admitted 6 guests that had returned who required more support either with referrals or respite services. Data shows that Sally's Place have served and supported 23 Females, 53 males and two unclassified.
b. **FY 2018-19 Impact:** During FY 2018-19 Sally's Place impacted 40 African Americans, 26 Caucasian, 4 Mexican/Mexican Americans, 2 Vietnamese, 1 Filipino, 1 Native American, 1 Asian, 1 Other Asian, 1 Other Southeast Asian, 1 Other Pacific Islander, 6 Other Non –Caucasian community members.

   Having only 6 guest's return for services at Sally's Place may mean that they are getting better or are connected to supportive services.

   According to our guest exiting survey most of the guests were pleased with the Peer support service given and felt hopeful even connected, after working with the Peer Advocate on the 4 phases during their duration of stay at Sally's Place. During Phase #1 the 1-2 days the guest and the Peer Advocate work on the Welcoming and Program overview. During phase #2 –Day 2-6 is spent working on Connections with family and outside social services that the guest would qualify for in Alameda County. Phase #3-day 6-8 is when the Peer Advocate works with the guest on Reflection, checks on how the referrals are going and if any of the referrals were helpful; during this phase the guest would be supported on creating a list of supporters or local sponsors. This is intended to let guest know they're not alone. The Sally's Place team collaborates on alternatives needed for challenging situations and on Phase #4 day 10-14 is the Preparation phase by where the staff and the Peer Advocate will continue to encourage the guest with tools of hope and motivating words. Also reminds the guest that Sally's place staff are here to support her/him/them with information and resources even after exiting Sally's

Place. By creating the four Phases chart we will be able to ensure that we give complete care and support to each guest that Sally's Place comes in contact with, and that it's well documented.

II. Please describe ways that the program strives to:

a. **Reduce mental health stigma:** Here at Sally's Place we do not focus on diagnosis; even the staff have lived experiences which they share with the guests to demonstrate how recovery and wellness are possible in spite of mental health stigma. The staff provide compassion and support to encourage, educate and teach many tools or ways to advocate for themselves are given while guests are using the respite services here at Sally's Place.
b. **Create a welcoming environment:** At Sally's Place we keep the house safe and clean at all times. Before guests arrive all the staff are made aware of the arrival date and time. The staff that are on shift on the designated date prepares the room for the guest to arrive. There are times the guest doesn't have transportation so the Peer Advocate will provide the transportation to Sally's Place free of charge. When the guest arrives the two staff on shift comes to meet the guest at the door with introductions and one of the staff shows the guest around the house, to their room, and before completing necessary welcoming packet the staff ask the guest if they would like to sit down and caught their breath first and maybe have a bite to eat.

III. Language Capacity for this program: Among the majority of the staff at Sally's Place, all speak English and here at Sally's we make an effort to have at least 1 Spanish speaker on each shift. When guest arrive to Sally's Place and there is a language barrier we connect the guest to the Language Line, staff can access interpreters speaking many languages via phone – and most languages are available on-demand.

IV. FY 2018-19 Additional Information: The Peer Support Specialists have taken to this model of Peer Support and consumers movement of power of choice and the whole team takes pride in supporting, encourging , empowering and advocating for the guests that stay at Sally's Place or even the guests that just need over the phone referrals or peer counseling and resouce linking.

At Sally's Place Peer Respite we serve guest from age 18 and older. The youngest guest that received services from Sally's Place was 21 yrs. old and the oldest guest was 72 yrs. old.

Sally's Place has continued to collaborate and receiving referrals from Alameda County CBO'S programs such as; Alameda County Emergency Medical Services (EMS), Mobile Evaluation Team -Fremont Police Department, La Familia, Fred Finch, Cherry hill Sobering station, Cherry hill Detox station, John George Psychiatric Hospital, Jay Mahler, Berkeley Drop In Center, Alameda County Mental Health Network, Sausal Creek, Homeless Action Center –Oakland, Berkeley Mental Health, BACS, Social workers- Stanford Valley care Hospital, Alameda County Family services, Families and Friends.

V. FY 2018-19 Challenges: Even though we have a current process on reaching the interested, pending and return guests that are on the waiting list still face challenges with matching the bed availability to the immediate need for respite services. Sometimes when the bed becomes available here at Sally's Place we have difficulty making contact with the next guest which sometimes results in a waitlist.
Sally's Place has continuously received referrals that exceeds the established bed capacity. That is, we have far more people who are interested – and qualify for – services at Sally's Place than we do available beds. This is good because it means that word is getting out about our services and that guests and

providers are sharing their positive experiences, but the challenge for staff is holding the knowledge that many of these individuals will go unserved.

It is also challenging when we receive a referral from an case manager, they will give a qualifying address for the guest, but once the guest arrives to Sally's Place, the guest will state that they are effectively homeless. Our current resolution is to forward the information to our Peer Advocate who works on housing during the 14 day stay. We have been successful in finding a housing option for these guests upon exit from Sally's Place. In order to resolve this, we do our best to be as clear as possible about the criteria and explain the rationale to referring providers. We have also worked to identify alternatives to Sally's Place for individuals who do not meet our criteria.

Another challenge that some of the staff at Sally's Place is with staff sharing their personal story in ways that can be triggering to guests; the staff have been coached on how to do more listening and how to thoughtfully gauge how much self-disclosure is useful and helpful for the guests.

VI. FY 2019-20 Projections of Clients to be served: Our goal for FY 2019-20 Sally's Place Peer Respite would be to serve and admit 144 guests with 109 of those guests unduplicated. Which means that we can only re-admit 3 guests a month for FY 2019-20.

VII. FY 2019-20 Program or Service Changes: Sally's Place Peer Respite is a brand new program. We are the first Peer run Respite in Alameda County. We make constant changes but over all our service delivery model remains the same.

A. COMMUNITY SERVICES & SUPPORTS (CSS) PROGRAM SUMMARIES
FY 2019-20 MHSA PLAN UPDATE
COMMUNITY SERVICES & SUPPORTS (CSS) UPDATE REPORT

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 31

PROVIDER NAME: Family Service Agency of San Francisco (FSA)

PROGRAM NAME: Felton Early Psychosis Programs - (re)MIND® and BEAM (formerly PREP Alameda)

Program Description: The Felton Early Psychosis Programs - (re)MIND® and BEAM - formerly known as PREP Alameda, provide evidence-based treatment and support for transition age youth (TAY) who are experiencing an initial episode of psychosis or severe mood disorder. We provide outreach and engagement, early intervention services and outpatient services that include: Mental Health Services, case management/brokerage, medication support/dispensing, crisis intervention and Individual Placement and Support (IPS) supported employment and education services. The service goals of (re)MIND® and BEAM Alameda are to delay or prevent the onset of chronic and disabling psychosis and mood disorders; reduce client hospitalizations and utilization of emergency services for mental health issues; improve the ability of clients to achieve and maintain an optimal level of functioning and recovery as measured by a functional assessment tool; connect clients with ongoing primary healthcare services and coordinate healthcare services with clients' primary care providers; increase educational and/ or vocational attainment among clients; increase meaningful activity as defined by the client; decrease social isolation among clients; and assist clients with advocating for adjustment of medications to the minimum amount necessary for effective symptom control.

Target Population: Transition Age Youth (TAY) ages 16-25, who are experiencing the onset of first episode psychosis associated with serious mental illness (SMI).

I. FY 2018-19 Outcomes:

a. **Number of unique consumers/clients served:** We served a total of 58 unduplicated clients from July 1, 2018- June 30, 2019.
b. **FY 2018-19 Impact:** Overall during FY 2018-19, we have been able to successfully meet our three impact objectives: reducing number of psych hospitalizations, decrease number of incarcerations, and clients having stable housing within 6 months of enrollment. The following success stories illustrate these achievements. The first success story involves a high school student experiencing psychosis. Like many of the young people we serve, they had experienced multiple psychiatric hospitalizations when they enrolled in the Felton Early Psychosis program in Alameda County. This young person's first hospitalization was due to being at-risk for self-harm and experiencing distressing auditory hallucinations and disorganized thinking and behavior. In addition to their increased psychiatric symptoms they also experienced other life stressors including the loss of their adoptive mother. Due to stressors and increased psychosis, they continued to experience multiple hospitalizations and needed support to regain stability in the community. Luckily, this young person had a supportive extended family where their adoptive grandmother and siblings sought services and helped them connect with specialized treatment. Over the course of several months this young person worked with our staff therapist and learned skills to identify triggers to symptoms and coping strategies to minimize delusions and thoughts of suicide. Through the course of treatment they were able to gain insight into their symptoms, practice learned skills and coping strategies, and their symptoms stabilized. This young person will be graduating high school this year and will attend junior college in the Fall. The second success story involves a young person who had multiple psych hospitalizations due to grave disability and suicide ideation. This young person also reported experiencing

distressing auditory hallucinations, disorganized thinking, depressed mood and increased substance use. Over the course of 2 years of treatment, this young person worked with our staff therapist and learned skills to identify triggers to symptoms and coping strategies to minimize delusions and suicidal thoughts. This young person was able to gain insight into their illness, stopped using substances, practiced learned skills and coping strategies and their symptoms stabilized. This young has successfully graduated from our program, is currently working full time, is involved in advocacy work, and is planning to enroll in school in the fall. The third success story involves a young person in high school. When this young person first arrived at our program, they were just hospitalized for aggression, command hallucinations, delusions, and bizarre behaviors. Some examples of this young person’s symptoms were punching walls, verbal abuse towards family members, and cawing like an eagle. Through the course of treatment, the staff therapist was able to engage this young person by relating to their interests in Aztec and Mayan culture, such as the eagle from the Legend of Tenochtitlan. The young person and staff were able to create a plan that involved weekly psychotherapy and medication management which effectively decreased the symptoms. They were able to grow their interest in construction and enrolled in ROP classes. The young person is doing well, has graduated from the Early Psychosis program and will be graduating from high school this summer. The last success story involves a young person experiencing a first onset of psychosis. This young person's symptoms revolved around hypercritical auditory hallucinations that impaired their ability to maintain a job. More specifically, the young person's auditory hallucinations were so intense they began yelling back at the voices while at work. In order to cope with the voices, this young person started smoking marijuana. However, this coping strategy only provided temporary relief as the voices quickly increased with greater intensity. This young person's marijuana use became a source of family turmoil as it jeopardized their housing situation. Fortunately, this young person was highly motivated to change. The treatment team and this young person agreed to a harm reduction plan by reducing the frequency of substance use and trying a different strain of marijuana that would not exacerbate their psychosis symptoms. With the support of this young person's treatment team, this young person was able to obtain a job, speak at public venues about his recovery, complete his probation requirements, continue to have stable housing and graduate from our program.

II. Please describe ways that the program strives to:

a. **Reduce mental health stigma:** In order to reduce mental health stigma, staff continues to educate clients and families to normalize the experience of mental health challenges. In addition, staff uses various strategies that are non-stigmatizing and non-discriminatory with the clients and families we serve. In addition, as a part of our new hire orientation, staff is required to go through several trainings regarding cultural sensitivity, SOGI and creating a welcoming and safe environment. In addition, staff has a client-centered and use non-discriminatory language when addressing the client and their family. It is also our general practice, regardless if the client is present, to always use non-discriminatory language and work from a strengths-based model.
b. **Create a welcoming environment:** In the office, we have created a space that is TAY friendly where clients are able to engage in activities, socialize with other peers, and have access to the computers and information about other community resources. The staff is culturally sensitive to the clients and their family’s needs and uses client-centered and non-discriminatory language when speaking with them.

FY 2019-20 MHSA PLAN UPDATE
COMMUNITY SERVICES & SUPPORTS (CSS) UPDATE REPORT

III. Language Capacity for this program: Currently, our language capacity for the program is for two additional languages, Spanish and Gujarati, in addition to English. In addition, we have access to interpreter services as needed for other threshold languages.

IV. FY 2018-19 Additional Information: None

V. FY 2018-19 Challenges: During most of the FY 2018-19, we operated with multiple unfilled staff positions which created challenges that resulted in smaller caseloads, less referrals and more reliance on other community resources. Due to these open positions (that included both management and line staff), as well as to transitioning out of previous contractual partnership (previous partner held the administrative oversight function for the program), we addressed pervasive quality assurance issues. Therefore, most of Q2 and Q3 focused on updating charts to meet Medi-Cal standards. During Q4, although the program was almost fully staffed, new staff onboarding and training impacted capacity to increase caseloads rapidly and we continued to rely on other community resources. Another challenge was having the need to slow down referrals in Q3 which impacted the flow of referrals in Q4 (which continued to be low). Moreover, during Q4, we also relocated to another site which required a new site certification.

VI. FY 2019-20 Projections of Clients to be Served: We are expecting to serve 100 unduplicated clients in the next fiscal year.

VII. FY 2019-20 Program or Service Changes: For FY 2019-20, we will begin to enroll 15 years old clients, on a case-by-case basis, experiencing onset of psychosis or severe mood disorder within the previous two years.

FY 2019-20 MHSA PLAN UPDATE
COMMUNITY SERVICES & SUPPORTS (CSS) UPDATE REPORT

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 32

PROVIDER NAME: Crisis Support Services of Alameda County

PROGRAM NAME: Suicide Prevention Crisis Line

Program Description: The Suicide Prevention Crisis Line is a 24-Hour Crisis line provided by Alameda County Crisis Support Services to provide: Crisis counseling in order to reduce the incidence of suicidal acts; lessen the number of psychiatric hospitalizations needed by individuals with suicidal thoughts; resolve crises; decrease self-destructive behavior; and increase awareness of suicide risk factors.

Target Population: The Suicide Prevention Crisis line provides a 24-Hour phone line for assistance to people of all ages and backgrounds during times of crisis, or their families, to work to prevent the suicide. Translation is available in more than 140 languages. We also offer teletype (TDD) services for deaf and hearing-impaired individuals.

Note: The crisis line program responds to calls on our 24 hour crisis lines (1-800-309-2131), National Suicide Prevention Lifeline (1-800-273-8255), ACCESS afterhours (1-800-491-9099), and Substance Use Helpline After hours (844)682-7215.

I. FY 2018-19 Outcomes:

a. **Number of unique consumers/clients served:** 9,343 unique clients on all 4 lines
    a. Crisis Line (1-800-309-2131) - 2893 clients
    b. National Suicide Prevention Lifeline (1-800-273-8255) – 3700 clients
    c. ACCESS Afterhours (1-800-491-9099) - 1983 clients
    d. Substance Use Disorder Helpline Afterhours (1-844-682-7215) - 767 clients

b. **FY 2018-19 Impact:** The program director would like to explain why the first impact was not met. In reflection, callers with suicide risk rating of 1 are unlikely to report a reduction in suicidal intent because they are already low intent at the start of the call.

When only callers with suicide risk 2 and above are included in the measure (the caller is at medium risk of suicide at the start of the call), then the impact outcome is 29.9% of crisis line callers with a risk level of 2 or higher self report a reduction in suicide intent from the initiation of the call to the end of the call and among those who report suicide intent at the start and end of the call.

FY 2019-20 MHSA PLAN UPDATE
COMMUNITY SERVICES & SUPPORTS (CSS) UPDATE REPORT

IMPACT MEASURES	IMPACT OBJECTIVES	ACTUAL IMPACT	Objective Met?
The percent of crisis line callers with a risk level of 1 or higher who self report a reduction in suicide intent from the initiation of the call to the end of the call among those who report suicide intent at the start and end of the call.	At least 20%	14.8%	No
The number of duplicated crisis line callers with risk level 3-5 who have been stabilized at the end of the call without law enforcement or hospital intervention.	440 duplicated callers	838 duplicated callers	Yes
The percentage of duplicated crisis line callers with risk level of 3-5 who were stabilized by the end of the call without law enforcement or hospital intervention.	At least 80%	83.5%	Yes

II. Please describe ways that the program strives to:

a. **Reduce mental health stigma:** The overall strategy of reducing mental health stigma in the program include providing training about mental health diagnosis and the bio-psycho-social impact on people living with mental health challenges, valuing and supporting staff and volunteers with lived experience, and aiming to create an environment for clients and service providers to be seen, heard and welcomed. The program actively works to mitigate the power imbalance experienced by mental health service consumers with a mental health system. We train our team to see people as people first, not just by their mental health diagnosis. Here are more detailed descriptions of each initiative:

- **Activating Hope Project** - CSS received technical support from Activating Hope, funded by the National Suicide Prevention Lifeline, to identify and implement best practices for positive engagement of lived suicide experience at CSS. The project seeks to build upon the lived experience of people who have been through suicidal struggles to help others and prevent future suicidal behavior. A committee with members of all the CSS programs and organizational levels met three times to recommend policies, practices, and programs that will further reduce mental health stigma within our agency and to serve clients more effectively. A survey was administered to measure the level of stigma, support and individual wellness within the agency. Some of the action items of the committee included, but are not limited to, exploring the costs and benefits of self-disclosure, creating training for staff and volunteers to appropriately share their lived experience within the context of the program goals, and creating a calming and healing environment. This is an active committee and their work will continue into the next fiscal year.
- **Cultural Humility Training** is provided for all incoming program staff and volunteers. The goal of the training is to build a foundation for an ongoing process to increase our effectiveness working

and communicating in a diverse and multicultural context within our organization and with the people we serve. Staff and volunteers practice multicultural communication skills to build a safe, inclusive organizational culture where all voices are heard, valued, and respected, including those who live with mental health challenges. In the training, program staff and volunteers develop a shared understanding of key concepts and terms related to cultural humility, power, privilege and oppression, and integrate that knowledge into our ongoing practices. Staff and volunteers build capacity to bring personal awareness of social identities, power, privilege, bias and assumptions into our interactions with each other (colleagues), and with the people we serve. Finally, we apply cultural humility principles to develop a framework for thinking about our callers who live with ongoing mental health challenges.

- **Mental Health First Aid** training is provided on site twice annually for all program staff and volunteers.
- **Point-in-Time Program Demographic Survey Fall 2018** was administered between August and October 2018 to measure the diversity of program staff and volunteers. The response rate was about 66%, with 100 completed responses. Five questions regarding lived experience were included. At CSS, program staff and volunteers routinely interface with people with lived experience as supervisors, colleagues, crisis line shift partners and friends. They are provided experiences that go beyond the negative mental health stereotypes and stigmas to form a richer understanding of people living with mental health challenges. We hope that the program reduces mental health self-stigma for people who self-identify with lived experience by valuing and supporting staff as active participants in meeting program goals.

Question on demographic survey about lived experience	% Yes response
Does someone close to you live with one or more mental health concerns?	90.8%
Is there someone close in your life, who has lived experience with suicidal thoughts, feelings and/or actions?	90.8%
Has someone close to you died by suicide?	30%
Do you live with one or more mental health concerns?	56.6%
Do you have lived experience with suicidal thoughts, feelings, and/or actions?	58.6%

b. **Create a welcoming environment:** Many of the initiatives described in the previous section also support creating a welcoming environment for clients. This year, the program director created clear boundaries and consequences for clients who used abusive, aggressive or unsafe language. Callers who use abusive or unsafe language or behavior are provided feedback by the program coordinator or director. Continued abusive behavior resulted in suspension of services. The clear boundaries and consequences reduced the frequency of mal-adaptive behavior from our clients, and increased the capacity and good will of program staff and volunteers to serve the client.

Staff shift supervisors, who work 8-40 hours/week on the crisis lines, are provided one-on-one supervision, as well as a confidential counter-transference process group where staff can safely discharge vicarious traumatization related to providing care to clients. In the group, shift supervisors build skills and resilience tools to support their work, including staying patient and welcoming when clients are most symptomatic.

III. Language Capacity for this program: The program accesses a translation service that is available 24/7 and includes over 140 languages.

IV. FY 2018-19 Additional Information: In February 2019, the program successfully expanded follow up care for clients on the Lifeline who presented with medium to high risk for suicide, but did not require law enforcement or hospital intervention. Follow up calls were opportunities for the program to reconnect with clients after their initial call to provide ongoing support, additional suicide assessment and intervention, additional safety planning, and connection to resources. 163 referrals were made by crisis line staff and volunteers, and 112 people received at least 1 follow up call (67.87%). The number of outreach calls to medium-high suicide risk callers increased by 138% from 117 calls in FY 2017-2018 to 279 calls in FY 2018-2019. The time spent on the phone through outreach calls increased 239% from 1,145 minutes in FY 2017-2018 to 3,881 minutes in FY 2018-2019. The outreach calls provided additional opportunities for the client to receive emotional support and a safety net. The service is not therapy and not a substitute for professional psychiatric help. Rather, through one or more conversations the follow up counselor collaborates on a plan to keep the client safe through a crisis and ways to get the client connected to a support system. Each conversation is scheduled one at a time, and the client is invited to reach the crisis lines as needed.

V. FY 2018-19 Challenges:

- Over the last 5 years, we have seen a steady increase in high risk calls and new callers to our crisis lines. This is due to factors outside our control, including increased media attention after prominent celebrity suicide deaths.
- As the crisis system delivery expands, the program anticipates a greater number of appropriate referrals from other parts of the Alameda County crisis continuum of care to our Crisis Lines and ACCESS lines after hours. Knowledge and skill expectations and workload on the ACCESS after-hours line has increased as we now function as dispatch for Mobile Crisis Team M-F 5pm-8pm. As the MCT expands to weekends, our responsibility to dispatch the Mobile Crisis Team will expand to the weekends as well.
- The ACCESS line after hours is subject to CA-DHCS regulations regarding 24/7 Access lines. The program receives 1-4 test calls from ACBH Quality Assurance. The program also participates in, and is held accountable to, the DHCS triennial review. The next review will be scheduled for

January 2020. To ensure compliance with DHCS regulations, regular training and oversight is necessary. This includes online training modules, in class training, detailed call review and greater supervision demands. The last Triennial Review was January 2017. CSS answered 5 out of 7 test calls and were deemed in compliance on 4 calls, and partial compliance on 1 call. The program is committed to doing well at the next Triennial Review.

- Utilizing a volunteer workforce poses its own set of challenges, including annual volunteer turnover, maintaining a high level of skill with a diverse team of volunteers, and quality control and oversight. A typical volunteer shift is 4 hours/week, and so a volunteer's skills and knowledge may not have the benefit of repetition and exposure. To mitigate these challenges, the program utilizes staff shift supervisors who provide consultation and ongoing training and oversight.

VI. FY 2019-20 Projections of Clients to be Served: 9,000 clients on all 4 lines.

VII. FY 2019-20 Program or Service Changes: The program will continue to expand follow up services for people medium to high risk for suicide. The program will also explore reducing call volume from callers who meet both of the following criteria (1) the caller does not live in Alameda County (2) the caller does not pose active suicide risk or any other safety risks. The program will also play an integral role in the expansion of county-wide crisis services by making referrals to the appropriate program.

FY 2019-20 MHSA PLAN UPDATE
COMMUNITY SERVICES & SUPPORTS (CSS) UPDATE REPORT

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 33

PROVIDER NAME: Family Service Agency of San Francisco

PROGRAM NAME: Deaf Community Counseling Services

Program Description: DCCS provides outpatient mental health services, including assessments, individual psychotherapy, family therapy, collateral and indirect services to provide information and referrals to community members.

Target Population: DCCS provides services for residents of Alameda county who have medi-cal, medi-medi or who are medi-cal eligible who are Deaf, DeafBlind, deaf with additional disabilities, late Deafened (those who were born hearing and became Deaf or lost their hearing in adulthood), hard of hearing (those who do not use sign language but use spoken language), from age 5 years to older adults. We also work with parents and family members of Deaf children or adult Deaf children. For the rest of this report, the word: "Deaf" will be used to include all clients with any kind of hearing impairment or loss or preferred communication mode.

I. FY 2018-19 Outcomes:

a. **Number of unique consumers/clients served:** DCCS provided direct services to 28 Deaf adults and 9 Deaf children and their families. We also provided indirect services, such as phone calls for referrals, and provided community workshops and presentations, so estimated people we served is at least 200-250.
b. **FY 2018-19 Impact:** DCCS has made positive impact on the community in increasing awareness of accessible mental health services in American Sign Language through our workshops and presentations to the Deaf community and assist the community to become more educated, more aware, and as a result, a more supportive community for all. DCCS creates positive impacts on individuals and families by providing direct services to Deaf clients and families we assist Deaf clients in managing their mental health conditions or reducing their symptoms so that they can function better within their families, communities and in their jobs. For example, we have worked with Deaf clients who have chronic depression with some risk for suicide so our work has reduced risk for suicidal behaviors and to increase functioning. We also work with Deaf children diagnosed with ADHD or Oppositional Defiant behaviors or anxiety and struggling both at home and school and work with these children and their families to reduce their impairment in their functioning and to get along better with peers, families and able to learn in the classroom. We also work with Deaf women or men in domestic violence relationships, helping them to improve their functioning and safety and reduce their personal risk. We also help Deaf individuals with severe mental illness change their lives such as how we helped one Deaf individual. This particular client was a Deaf male, age 48, who was arrested for stalking and attempted assault. With our assessment in his preferred language, American Sign Language, it was discovered this Deaf client had an undiagnosed psychotic disorder, and substance abuse disorder, so with an accurate diagnosis, treatment, medication, reduced substance use and then linkage to a job training program for Deaf people, this Deaf client was able to begin and keep a job, then secured stable housing and reconnected with his family again. Without access to our clinical team with whom he could communicate with easily in sign language, client may never have gotten accurate diagnosis, treatment and medication or re-established family relationships

or may have returned to the criminal system. We have more similar stories about transformed lives.

II. Please describe ways that the program strives to:

a. **Reduce mental health stigma:** DCCS provides psycho-educational presentations and workshops about mental health to explain, educate and share about resources to Deaf community. DCCS also consults with other agencies that provide services to Deaf community to provide education and consult about mental health conditions. DCCS also partnered with 2 other organizations in Deaf community in Bay Area last May 2019 to host an all day, first of its kind workshop for Deaf community, called "My Mind Matters." In this workshop we featured speakers who are Deaf, people of color, who also struggled with mental health conditions and shared their journeys of their recovery, what they did to get help through therapy, medication and social support. This was very successful and word of this workshop spread through the national Deaf community, who are requesting the same kind of workshop in their areas.
b. **Create a welcoming environment:** All of DCCS staff are fluent in sign language and also open to respect and utilize whatever mode of communication the Deaf individual prefers. We are culturally sensitive to Deaf culture values, norms and experiences.

III. Language Capacity for this program: DCCS staff must be flexible in using communication modes when working with Bay Area Deaf clients. Deaf individuals living in the Bay Area often have many different modes of communication, not only American Sign Language, some use spoken English. Often Deaf clients come from families where primary language is Spanish or Tagalog. Although our DCCS staff are all fluent in American Sign Language, we also utilize certified sign language interpreters as needed to communicate with family members who may not be fluent in sign language. We use other spoken language interpreters, such as Spanish, for working with families, with parents who are Spanish speaking and have a Deaf child. When a Deaf client is from another and has fluency in spoken Tagalog, but not spoken English language or American Sign Language, then we are flexible in using writing back and forth if that is best way for the client to communicate. Other Deaf clients have additional disabilities, such as intellectual impairment, limited language skills, or need Pro Tactile sign language for individuals who are both Deaf and Blind, so staff must be linguistically flexible, skilled and ready to accommodate the various communication modes that Deaf people use.

IV. FY 2018-19 Additional Information: Studies show the rate of Deaf individuals having a mental health diagnosis, whether for depression, anxiety or psychosis are either comparable (not higher than) the average person or are definitely slightly higher for depression and anxiety. However, when Deaf individuals do have a diagnosis, it takes longer to treat, due to delay of finding adequate and linguistically and culturally appropriate services for earlier intervention. Treatment may also take longer due to lack of access to other community resources that others take for granted, providing additional strain on the mental health service provider to do more to assist the Deaf clients in their recovery. For example, such as substance abuse treatment programs, inpatient or outpatient, AA programs, or even other informal support groups such as support groups for parents with ADHD children do not provide access for those with any kind of hearing loss or deafness but can play a significant role in providing help and support for many people in their recovery. 2. Providing mental health services using interpreters is not the ideal and often not the most culturally or linguistically sensitive way to provide adequate and sufficient mental health treatment. We have many Deaf clients who come to us after being unsatisfied with using interpreters with other hearing mental health providers.

FY 2019-20 MHSA PLAN UPDATE
COMMUNITY SERVICES & SUPPORTS (CSS) UPDATE REPORT

V. FY 2018-19 Challenges: There is a long history of and continues to be an issue of Deaf being underserved minority as far as accessing mental health treatment and resources. There is still much stigma about accessing mental health resources and medications. Working with Deaf is especially harder when Deaf clients cannot access other social support systems due to lack of sign language access such as AA, Al Anon, parent support groups and many other important resources that are available to those without hearing loss. 2. Maintaining a program for Deaf community is challenging is that it is difficult to find trained mental health professionals who are also skilled in sign language, knowledgeable about working with various Deaf individuals and their issues, experiences and cultural values and practice cultural sensitivity to working with Deaf individuals, with the stance of "working with, rather than "for "the Deaf client." One cannot hire mental health professionals and expect them to become "fluent "in sign language, which often takes years of training and practice.

VI. FY 2019-20 Projections of Clients to be Served: DCCS aims to provide services to 20 new Deaf individuals and their families, to reach 200 Deaf individuals or service providers in Deaf community in workshops and presentations. We will continue to use flyers to circulate and reach out to others. We are planning to another annual "My Mind Matters" workshop this coming spring 2020, and believe we will reach a higher number of participants.

VII. FY 2019-20 Program or Service Changes: DCCS is closing its San Leandro location and moving to Berkeley in a few weeks. The new location in Berkeley is in the Ed Roberts Campus and this will enhance our ability to continue to provide outreach and services as we will be able to work with other organizations at this site, who also serve Deaf clients. This location is also very accessible and easy for our Deaf community to get to. We are also currently looking for one more clinician who is fluent in sign language and can provide mental health services so that we can serve more clients.

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

Alameda County implements a variety and continuum of Prevention and Early Intervention (PEI) programs, which promote three core strategies: "preventing mental illness from becoming severe and disabling and improving timely access for underserved populations. Additionally, PEI services must be designed, implemented, and promoted using Strategies that are Non-Stigmatizing and Non-Discriminatory."[1]

PEI programs promote health and wellness and emphasize strategies to reduce seven negative outcomes that may result from untreated mental illness:

- Suicide
- Incarceration
- School failure or dropout
- Unemployment
- Prolonged suffering
- Homelessness
- Removal of children from their homes

As Alameda County works to fully incorporate the new Mental Health Services Oversight and Accountability (MHSOAC) approved Prevention and Early Intervention Regulations into community services, program administrators will focus future efforts to measure how effectively programs are mitigating these outcomes.

California's historic commitment to prevention and early intervention through Prop 63 moves the mental health system towards a "help-first" instead of a "fail-first" strategy. PEI identifies individuals at risk of or indicating early signs of mental illness or emotional disturbance and links them to treatment and other resources.[2]

Alameda County's PEI programs create partnerships with unserved and underserved ethnic and linguistically isolated communities, schools, the justice system, primary care and a wide range of social, wellness, cultural and spiritual support services and community groups. In addition to these partnerships, the county has also placed prevention and early intervention services in convenient locations where people receive and participate in routine health care, wellness, leisure, educational, recreational, faith and spiritual healing and other activities that promote social connectedness and individual, family and community functioning. MHSA specifies that all funded PEI Programs must include the following strategies:

- **Outreach** to families, employers, primary care health care providers, and others to recognize the early signs of potentially severe and disabling mental illness;

- **Access and linkage** to medically necessary care…as early in the onset of these conditions as possible;

- **Reduction in stigma and discrimination** associated with either being diagnosed with a mental health condition or seeking mental health services (MHSA, Section 4, Welfare and Institutions Code (WIC) § 5840(b)).

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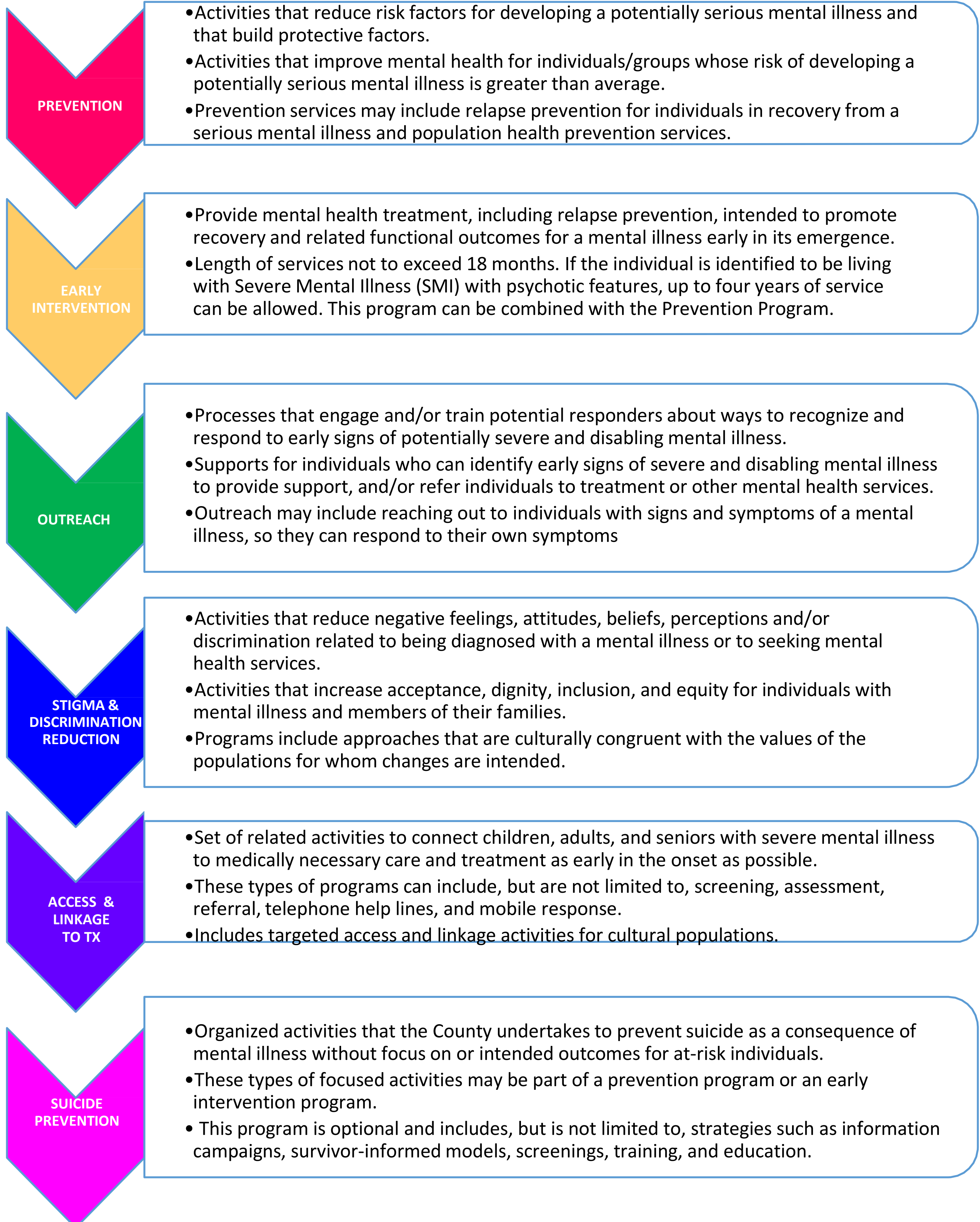
[1] Proposition 63: Mental Health Services Act 2004

[2] MHSOAC PEI Fact Sheet, December 201

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES



Prevention Program PEI Data Report FY 18/19

MHSA Program Number: PEI 1A
Program Name: School-Base Mental Health Consulation in Preschools- Blue Skies Mental Wellness Team

The Blue Skies Mental Wellness Team (BSMWT) provides families participating in home visitation and family support ACPHD-MPCAH programs with clinical case management, brief therapy and case consultation-case review services. This ACPHD-MPCAH program provides support services for Perinatal Mood Disorders and other emerging or diagnosed mental health concerns to provide stabilization, referrals and resources to families.

General Information & Total Numbers Served

Total Numbers Served through PEI MHSA		
Number of unduplicated individuals your program serves who are at-risk of developing a serious mental illness (SMI)	A	99
Number of unduplicated individuals your program serves who show early signs of forming a more severe mental illness	B	0
Number of unduplicated individual family members served indirectly by your program:	C	0
Grand TOTAL of unduplicated individuals served in the Quarter that you are reporting about. [This number (D) should = A=B+C.]	D	99

DEMOGRAPHICS

Age Group (Unduplicated)	
Children/Youth (0-15)	42
Transition Age Youth (16-25)	21
Adult (26-59)	36
Older Adult (60+)	0
Unknown/ Declined to Answer	0

Race (Please mark only one choice) *If Hispanic or Latino, choose "Another race not listed."*	
American Indian or Alaska Native	1
Asian	1
Black or African American	36
Native Hawaiian or other Pacific Islander	0
White	9
More than one race	0
Another race not listed	12
Unknown/ Declined to Answer	40

Gender Identity (Please mark both parts A & B)	
A) Assigned sex at birth: (Please mark only one choice)	
Male	
Female	
Other sex not listed (e.g. Intersex)	
Unknown/Decline to Answer	99
B) Current Gender Identity: (Please mark only one choice)	
Male	
Female	
Transgender	
Genderqueer	
Questioning or Unsure of Gender Identity	
Another Gender Identity not listed	
	99

Ethnicity /Cultural Heritage (Please mark only once choice)	
If Hispanic or Latino, please specify:	
Caribbean	0
Central American	3
Mexican/Mexican--American/Chicano	18
Puerto Rican	0
South American	0
Another Hispanic/Latino ethnicity not listed	6
Unknown/Declined to Answer	30
If Non-Hispanic or Non-Latino, please specify:	
African	0
African American	33
Asian Indian/South Asian	0
Cambodian	0
Chinese	0
Eastern European	0
European	0
Filipino	1
Japanese	0
Korean	0
Middle Eastern	0
Vietnamese	0
Other Non-Hispanic or Non-Latino ethnicity not listed	8
More than one ethnicity	0
Unknown /Declined to Answer	0

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

Primary Language (Please mark only one choice)	
English	14
Spanish	6
Farsi	0
Cantonese	0
Mandarin	0
Other Chinese Dialects	0
Vietnamese	0
Korean	0
Tagalog	0
Other Filipino Dialect	0
Japanese	0
Laotian	0
Cambodian	0
Mien	0
Hmong	0
Samoan	0
Thai	0
Russian	0
Polish	0
German	0
Italian	0
Turkish	0
Hebrew	0
French	0
Portuguese	0
Armenian	0
Arabic	0
Sign ASL	0
Other primary language not listed	0
Unknown/ Decline to Answer	79

Sexual Orientation (Please mark only one choice)	
Gay or Lesbian	
Heterosexual or Straight	
Bisexual	
Questioning or unsure of sexual orientation	
Queer	
Another sexual orientation not listed	
Unknown/Decline to Answer	99

Disability Status (Please mark all that apply)	
None	99
Yes. If yes, please specify (choose from list below):	
Difficulty Seeing	0
Difficulty hearing, or having speech understood	0
Mental Domain	0
Physical/Mobility Domain	0
Chronic Health Condition	0
Another disability not listed	0
Unknown/Decline to Answer	0

Veteran Status (Please mark only one choice)	
Yes	
No	
Unknown/Decline to Answer	99

ADDITIONAL INFORMATION

Please include the number of clients and/or contacts you estimate to serve in:

FY 19/20: 100
FY 20/21: 101

Please tell us about any changes you intend to make to your program over the next two fiscal years and explain your rationale for making these changes: We plan to add two additional half time staff to work with our existing Blue Skies Mental Wellness Team of BHC's II who provide prevention brief therapy and clinical case management to our perinatal clients in public health home visiting to enhance our mental health supports provided in our department. The first half time therapist will offer perinatal mood disorder brief therapy to clients in need of parenting support and depression/anxiety management. The second half time therapist will provide consultation to a newly formed Health Education Team offering Group Psycho-Educational training support and will model fidelity oversight and debriefing for the team. We will continue to work on team building and focusing on ways to integrate our mental health clinicians, providing services to offer a consistent model of supportive, reflective and engaging consultation, brief therapy, clinical case management and mental health referral services for home visiting clients. We plan to continue to implement access to service linkages and treatment and to engage underserved perinatal populations to provide introductory offerings for mental health supports.

PREVENTION & EARLY INVERVENTION PROGRAM SUMMARIES UNDERSERVED ETHNIC LANGUAGE POPULATION (UELP) PROGRAMS

Each UELP program is built on a framework of three core strategies: 1) Outreach & Engagement, 2) Mental Health Consultation, and 3) Early Intervention services. These strategies are implemented through a variety of services, including one-on-one outreach events; psycho-educational workshops/classes; mental health consultation sessions with a variety of stakeholders (e.g., families, teachers, faith community, and community leaders); support groups; traditional healing workshops; radio/television/blogging activities; and short-term, low-intensity early intervention counseling sessions for individuals and families who are experiencing early signs and symptoms of a mental health concern.

Alameda County is an incredibly diverse population of over 1.5 million people. To address its diversity, Alameda County Behavioral Health (ACBH) has contracted thirteen programs to provide culturally responsive Mental Health PEI services to state-identified underserved populations, which include the communities of Afghan/South Asian, African, Asian/Pacific Islander (API), Native American, and Latinos. The following organizations provide these programs: [1]

- Afghan Coalition
- Asian Health Services
- Center for Empowering Immigrants & Refugees
- Community Health for Asian Americans
- Filipino Advocates for Justice
- International Rescue Committee
- Korean Community Center of the East Bay
- La Clinica de la Raza
- Native American Health Center
- Partnerships for Trauma Recovery
- Portia Bell Hume Center
- Richmond Area Multi-Service, Inc.
- Tri-City Health Center

Alameda County Behavioral Health (ACBH) worked with seven Underserved Ethnic Language Population (UELP) programs to develop an outcome-based survey. The survey was first given in 2014 and again in 2015. The outcome-based survey was revised in 2016 and split into two different data tools – the UELP Community Health Assessment and the UELP Community Wellness Client Satisfaction Survey.

[1] *FY 18/19 was the first year of UELP implementation for the following six providers:* ***IRC, RAMS, TriCity, PTR, FAJ, KCCEB.***

The health assessment and satisfaction surveys were disseminated to the UELP community in 23 different languages including English, Spanish, Vietnamese, Chinese, Dari, Hindi, Khmer, Nepali, Korean, Thai, and Burmese and covered the following outcomes:

- Forming and strengthening identity;
- Changing knowledge and perception of mental health;
- Building community and wellness;
- Connecting individual and family with their culture;
- Improving access to services and resources;
- Transforming mental health services; and
- Increasing workforce and leadership development.

The evaluation used mixed methods. To better understand the meaning of survey responses, ACBH also conducted focus groups and a key informant interview with the UELP program participants.

All UELP providers offer services in two main categories: 1) Prevention services, for clients who are at higher than average risk of developing a significant mental illness and 2) Preventative Counseling (PC) services, designed for clients who are showing early signs and symptoms of a mental health concern. Responses to these survey questions were analyzed separately for Prevention and PC services to measure any differences between the two types of services.

Key Findings

In FY 18/19, the data shows that UELP providers in total produced:

- 7,895 *Prevention* events, which is a 37% increase from last year;
- 56,848 people were served at these *Prevention* events (duplicated count); and
- 895 unique clients were served through *PC* services, which is an 18% increase in the number of clients served in FY 17/18.

The revised client satisfaction survey and focus groups were used to assess the program outcomes. All the critical findings of the analysis are summarized below.

In 2019, a total of 251 respondents from nine of the thirteen UELP programs completed the survey.

Forming and Strengthening Identity

Participants are more **empowered** and confident in themselves. Eighty-four percent of *Prevention* and *PC* respondents reported feeling better about themselves. While participating in their programs, they developed the strength, motivation, and courage to address their challenges.

Changing Individual Knowledge and Perception of Mental Health Services

Providers are working towards changing the perception and narrative around mental health. Eighty-eight percent of *Prevention* respondents and ninety-one percent of *PC* respondents reported having a stronger belief that most people with mental health experiences can grow, change, and recover. Each reporting year, more clients are reporting becoming comfortable sharing their experiences with people outside of their programs. Having these discussions more frequently and openly works towards normalizing mental health and reducing the **stigma** associated with it.

Building Community and Its Wellness

UELP providers are working towards a healthier community for their clients. Respondents reported ***establishing relationships*** because of their participation in services. UELP programs provide an instant community for clients and reduce the risk of social isolation. Eighty-six percent of *Prevention* respondents and ninety percent of *PC* respondents reported that they have people with whom they can do enjoyable things.

Connecting Individual and Family with Their Culture

UELP programs provide clients with opportunities to connect with their culture. Focus group/interview respondents reported that they had increased their participation in ***cultural celebrations and traditions*** since engaging with UELP services. Eighty-three percent of *Prevention* respondents and ninety percent of *PC* respondents reported feeling more connected to their culture and community.

Improving Access to Services and Resources

UELP programs strive to improve access to services and resources for their client populations. Respondents reported several examples in which their program has connected them to ***resources*** such as employment, legal services, voting rights, and health care. Eighty percent of *Prevention* respondents and eighty-one percent of *PC* respondents reported becoming more effective in getting the resources that they or their family need.

Transforming Mental Health Services

UELP programs are transforming the way mental health services are delivered in Alameda County. One example is by providing ***linguistic and cultural competency***. Services are offered to program participants in the language that they speak and by people who understand their cultural background. Eighty-eight percent of *Prevention* respondents and ninety-three percent of *PC* respondents also said that staff were sensitive to their cultural backgrounds.

Respondents reported strong ***relationships with service providers*** and often referred to staff as family. Ninety-three percent of *Prevention* respondents and ninety-seven percent of *PC* respondents reported that program staff treated them with dignity and respect.

UELP programs also provide a welcoming and ***safe space*** for their clients. Many respondents reported that “this is the place” where they come and tell their “secrets.”

Increase Workforce and Leadership Development

This outcome is still a new area of exploration for the UELP evaluation**.** However, data from the focus groups/interview indicates that UELP programs are creating opportunities with their clients for ***community leadership.***

Remaining Challenges

Focus group/interview respondents suggested the need for more community ***outreach.*** Other people in their communities are struggling with similar challenges and need to be aware of UELP services and its benefits.

Location was reported as a barrier to service for participants that may not have access to a car or live in a different city other than where their program is located.

Alameda County is still in a housing crisis. Housing access and affordability continue to be a large barrier for UELP program participants.

Additional Findings

Fiscal year 18/19 data demonstrates that UELP clients are benefiting from their services. Overall, respondents reported improved quality of life because of their participation in their programs but still reported a need for continued support. *PC* respondents are also benefitting from more intensive services from their UELP providers. The majority (80%) of *PC* respondents reported fewer crises, and half (50%) improved their overall health from the pre to post-assessment period. Very few respondents reported a worse score.

UELP Prevention Data Report FY 18/19

MHSA Program Number: PEI 5
Program Name: Outreach, Education & Consultation for Latino Community-
Cultura y Bienestar (La Clinica)

Cultura y Bienestar (CyB), La Clinica's UELP MHSA Prevention and Early Intervention program, serves Latinos throughout Alameda County through a three-agency collaboration. La Clinica de La Raza, the lead agency, serves Latinos in Northern Alameda County, La Familia Counseling Services serves the Central region, La Familia's East Bay serves the East County region, and Tiburcio Vasquez Health Center serves the Southern region of Alameda County.

GENERAL INFORMATION & TOTAL NUMBERS SERVED

Total Numbers Served through PEI MHSA		
Number of unduplicated individuals your program serves who are **at-risk** of developing a mental health problem or serious mental illness (SMI)	**A**	17,609
Number of unduplicated individuals your program serves who show **early signs** of forming a more severe mental illness	**B**	391
Number of unduplicated individual family members served indirectly by your program:	**C**	
Grand TOTAL of unduplicated individuals served in the Quarter that you are reporting about. [This number (D) should = A+B+C.]	**D**	18,000

DEMOGRAPHICS

Age Group (Unduplicated)	
Children/Youth (0-15)	3,958
Transition Age Youth (16-25)	2,699
Adult (26-59)	8,351
Older Adult (60+)	1,791
Unknown/ Declined to Answer	820

Race (Please mark only one choice) *If Hispanic or Latino, choose "Another race not listed."*	
American Indian or Alaska Native	3
Asian	376
Black or African American	
Native Hawaiian or other Pacific Islander	
White	
More than one race	
Another race not listed	17,230
Unknown/ Declined to Answer	

Sexual Orientation (Please mark only one choice)	
Gay or Lesbian	24
Heterosexual or Straight	6,598
Bisexual	
Questioning or unsure of sexual orientation	
Queer	1
Another sexual orientation not listed	74
Unknown/Decline to Answer	10,918

Ethnicity /Cultural Heritage (Please mark only once choice)	
If Hispanic or Latino, please specify:	
Caribbean	1,442
Central American	1,078
Mexican/Mexican--American/Chicano	6,775
Puerto Rican	44
South American	83
Another Hispanic/Latino ethnicity not listed	5,261
Unknown/Declined to Answer	
If Non-Hispanic or Non-Latino, please specify:	
African	
African American	
Asian Indian/South Asian	
Cambodian	
Chinese	
Eastern European	
European	
Filipino	
Japanese	
Korean	
Middle Eastern	
Vietnamese	
Other Non-Hispanic or Non-Latino ethnicity not listed	
More than one ethnicity	
Unknown /Declined to Answer	

Primary Language (Please mark only one choice)	
English	3,939
Spanish	13,394
Farsi	
Cantonese	
Mandarin	
Other Chinese Dialects	
Vietnamese	
Korean	
Tagalog	
Other Filipino Dialect	
Japanese	
Laotian	
Cambodian	
Mien	
Hmong	
Samoan	
Thai	
Russian	
Polish	
German	
Italian	
Turkish	
Hebrew	
French	
Portuguese	
Armenian	
Arabic	
Sign ASL	
Other primary language not listed	279
Unknown/ Decline to A...	

Gender Identity (Please mark both parts A & B)	
A) Assigned sex at birth: (Please mark only one choice)	
Male	5,745
Female	11,311
Other sex not listed (e.g. Intersex)	
Unknown/Decline to Answer	556
B) Current Gender Identity: (Please mark only one choice)	
Male	
Female	
Transgender	5
Genderqueer	
Questioning or Unsure of Gender Identity	
Another Gender Identity not listed	
Unknown/Decline to Answer	17,614

Disability Status (Please mark all that apply)	
None	4,428
Yes. If yes, please specify (choose from list below):	
Difficulty Seeing	10
Difficulty hearing, or having speech	16
Mental Domain	4
Physical/Mobility Domain	122
Chronic Health Condition	384
Another disability not listed	2
Unknown/Decline to Answer	12,653

Veteran Status (Please mark only one choice)	
Yes	41
No	5,914
Unknown/Decline to Answer	17,619

PROGRAM OVERVIEW

1. What were the successes/accomplishments of the past year? Please provide one example or case study of a success your agency is particularly proud of.

   Fiscal year 18-19 brought many major successes for CyB. First, the Cultura y Bienestar program was able to exceed most of the program deliverables. The activities that far exceeded program deliverables were workshops/support groups for seniors with a 327% achievement rate, early intervention visits with a 232% achievement rate, and fairs/community events with a 183% achievement rate. All of these efforts continue gaining the Latino community's trust and support.

   Also, traditional healing events have been the highlight of all the events provided during FY18-19. Community members have a vested interest in utilizing traditional medicine and traditional healing methods. For example, our clients have continued to show interest in therapeutic drumming circles as a form of wellness and the use of herbs as a form of medicine. This year alone, the Cultura y Bienestar has provided fourteen traditional healing events, many of which have focused on healing through herbal medicine.

   Moreover, Cultura y Bienestar not only has engaged the adults in the traditional healing events; the kids have been a part of these events as well. CyB engaged the kids through traditional story-telling. For one of the events, character dress-up was utilized as a story-telling technique. The kids really enjoyed the event and were extremely involved the entire time.

   Additionally, as part of the $1.14 Million CyB received from the California Department of Public Health, California Reducing Disparities Project, CyB continues to staff various positions to their full FTE. The funding has also allowed the advancement on evaluating CyB program model to see if CyB can be replicated in other Latino communities to reduce mental health stigma. The findings from the preliminary analysis suggest that the proposed target population is being recruited for the prevention services and that based on the client profiles, many have received some form of treatment for serious mental illness or other physical health problems.
   Lastly, CyB was heavily involved in making progress towards standardizing all program curricula and assuring that all CyB staff is providing the same trainings in a standardized format despite agency affiliation. La Clinica hired an MPH student intern to work with CyB staff develop the program manual. Technical Assistance Providers (TAP) from the California Reducing Disparities Project have assisted in reviewing the program manual drafts and have provided ongoing feedback to advance the development of the manual. Cultura y Biesntar expects to have a finalized the manual in FY19-20.

2. What were the challenges and how did your agency mitigate challenges?
   Due to the change in the political climate towards immigrants in recent years, there has been an overall decline in the rate of immigrants seeking out public services. To a great extent, this decline has been as a result of fear of the release of their personal information, which could have an impact on migratory status. La Clínica aims to draw on its history and expertise working with this population to strategize ways to mitigate fear and encourage participation in these important services. When clients come to receive services, CyB makes a welcoming environment and makes it clear that they can trust the program and that their personal will be kept safe and confidential.

   While outreach activities exceeded program deliverables, there continues to be enormous need to continue to outreach to our community as there are still many members of our target population who need services but are not aware about the services that CyB offers.

CyB will continue to strive to increase community outreach by participating in local events, partnering with other agencies, and continue to present of services that CyB offers.

3. Please describe the innovative ways your program has weaved the topics of mental health/emotional well-being into your activities. Please give at least one example.

   Mental health topics are woven into all of the program's activities, outreach, CBO trainings, individual, couple, family, and consultations with family and community members, as well as the traditional medicine workshops. Recently, CyB was able to weave in mental health/emotional well-being through consultation visit with a client. CyB had a client who visited CyB because he was having marital problems. CyB staff listened with an open-mind and allowed the client to share his feelings about his marriage and the impact they were having on his mental and emotional health. The staff also walked him through an activity to reflect on how the problems that he was experiencing were also taking a toll on his partner's mental and emotional health. He received information about ways to effectively communicate with his partner and how to relate better to each other. The client came back to share that the information he received has made a huge improvement in his marriage and wanted to receive more services such as men's group.

4. Please describe how your program has encouraged access to your services and your strategies for successful linkage for mental health treatment.
   All staff is expected to provide outreach to the communities that CyB serves. Staff provides outreach at community events, and various other locations where the Latino community congregates in order to provide information on mental health and the services that the program provides. Additionally, once CyB engages clients, staff completes referral forms so that the coordinator for the program can follow up and contact each client to see if they have followed through on the referral and in order to make additional referrals as necessary. CyB works directly with La Clinica medical providers to increase access for clients who are also La Clinica patients. For example, if a patient has been recently diagnosed with diabetes, the provider will continue to support the patient to improve their physical health and will refer the patient to CyB for staff to provide mental health support. Likewise, if a patient comes for mental health services but also needs medical services, CyB will refer them to La Clinica's medical department.

5. Describe how your program interacted with various other ACBH funded programs/projects such as school-based programs, other prevention programs, the stigma and discrimination reduction campaign, 10 x 10 campaign etc.
   CyB continues to maintain excellent relationships and collaborations Alameda County schools, head start programs, charter schools, school based health centers, colleges, migrant education programs, faith and community based organizations such as Covenant House, FERC, Mujeres Unidas y Activas, 67 Suenos, La Red Latina, St. Elizabeth's, the Unity Council, 10x10 Campaign, El Chante, CODA, Native American Health Center, BHCS programs/projects such as school based EPSTD services, COST meetings, Early Learning Network (ELN) and other prevention programs, The Stigma and Discrimination Reduction Campaign, Alameda County New Comer Immigrant and Refugee Community Center (Planning Committee). CyB staff continue to work with Casa CHE, La Clinica's prevention program, which serves the LGBTQQI community and at risk youth. CyB staff attends school open houses, health fairs, community events (Cinco de Mayo, Dia de Los Muertos, Mercado de La Noche, Church events) and any other events CyB is invited to.

6. What are your goals for your program for the upcoming fiscal year?

   CyB's primary goal for this upcoming fiscal year is to continue to expand to make services available to all community members who need it as well as to continue provide high quality care. Moreover, another goal for this upcoming year is to develop a youth leadership program at the schools that we currently partner with to empower young people to become our future leaders. Through this initiative, we hope to teach youth the skills required work in collaboration with their peers to overcome challenges, to teach youth how to be a mentor for others, and also to improve communication while at the same time weaving in mental health topics to this work.

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

ACCESS & LINKAGE TO MENTAL HEALTH TREATMENT (QUESTION 1 AND 3 ARE REQUIRED PER YOUR EXHIBIT A - QUALITY MEASURES)

1. Number of individuals with serious mental illness (SMI) or exhibit symptoms of a SMI who received a paper referral (i.e. referrals via phone do not apply) from your program…
   a. To an ACBH-funded mental health treatment program: 6
   b. To a non-ACBH-funded mental health treatment program: 2

2. List type(s) of mental health treatment programs the individual was referred to (i.e. outpatient, inpatient, etc.):
   Outpatient

3. Number of individuals who were successfully referred and linked (i.e. client has been seen at least once in person by a treatment provider):
   a. To an ACBH mental health treatment program: 6
   b. To a non-ACBH-funded mental health treatment program: 2

4. Average duration in weeks of signs of untreated mental illness (per client self-report) *(write "n/a" or "unknown" when applicable): 16 weeks*

5. Average time in weeks between when a paper referral was given to individual by your program and the individual's first in person appointment with a mental health treatment provider *(write "n/a" or "unknown" when applicable)*: 4 weeks

TIMELY ACCESS (TO OTHER PEI-FUNDED PROGRAMS)

1. Number of separate paper referrals to another ACBH **PEI-funded** program. *(write "n/a" or "unknown" when applicable)*: 0

2. Number of individuals followed through on referral & engaged in an ACBH PEI-funded program *(write "n/a" or "unknown" when applicable)*: N/A

3. Average time in weeks between when a paper referral was given to individual by your program and the individual's first in person appointment with the ACBH PEI-funded provider*(write "n/a" or "unknown" when applicable)*: N/A

UELP Prevention Data Report FY 18/19

MHSA Program Number: PEI 6
Program Name: Outreach, Education & Consultation for Asian Pacific Islander Community - Asian Health Services

Asian Health Services, founded in 1974, provides health, social, and advocacy services for all regardless of income, insurance status, immigration status, language, or culture. Our approach to wellbeing focuses on "whole patient health," which is why we provide more than primary care services, including mental health, case management, nutrition, and dental care to more than 27,000 patients in English and over 12 Asian languages: Cantonese, Vietnamese, Mandarin, Khmer, Korean, Tagalog, Mien, Lao, Thai, Mongolian, Karen, Karenni, and Burmese. We offer medical, dental, and mental health services for all ages.

GENERAL INFORMATION & TOTAL NUMBERS SERVED

Total Numbers Served through PEI MHSA		
Number of unduplicated individuals your program serves who are **at-risk** of developing a mental health problem or serious mental illness (SMI)	**A**	5,348
Number of unduplicated individuals your program serves who show **early signs** of forming a more severe mental illness	**B**	34
Number of unduplicated individual family members served indirectly by your program:	**C**	
Grand TOTAL of unduplicated individuals served in the Quarter that you are reporting about. [This number (D) should = A+B+C.]	**D**	5,382

DEMOGRAPHICS

Age Group (Unduplicated)	
Children/Youth (0-15)	799
Transition Age Youth (16-25)	892
Adult (26-59)	2,436
Older Adult (60+)	1,217
Unknown/ Declined to Answer	4

Race (Please mark only one choice) *If Hispanic or Latino, choose "Another race not listed."*	
American Indian or Alaska Native	2
Asian	4,632
Black or African American	118
Native Hawaiian or other Pacific Islander	7
White	133
More than one race	332
Another race not listed	113
Unknown/ Declined to Answer	11

Sexual Orientation (Please mark only one choice)	
Gay or Lesbian	31
Heterosexual or Straight	2,365
Bisexual	
Questioning or unsure of sexual orientation	69
Queer	56
Another sexual orientation not listed	2,876
Unknown/Decline to Answer	

Ethnicity /Cultural Heritage (Please mark only once choice)	
If Hispanic or Latino, please specify:	
Caribbean	
Central American	
Mexican/Mexican--American/Chicano	
Puerto Rican	
South American	
Another Hispanic/Latino ethnicity not listed	80
Unknown/Declined to Answer	
If Non-Hispanic or Non-Latino, please specify:	
African	
African American	
Asian Indian/South Asian	3
Cambodian	569
Chinese	1,552
Eastern European	
European	
Filipino	192
Japanese	25
Korean	194
Middle Eastern	
Vietnamese	1,492
Other Non-Hispanic or Non-Latino ethnicity not listed Lao -48 Mien - 391 Mongolian-29 Nepalese - 3 Samoan-3 Sri Lankan-2 Taiwanese – 17 Other Asian – 72 Other Pacific Islander – 1 Other South Asian – 21 Other South East Asian - 1	588
More than one ethnicity	
Unknown /Declined to Answer	

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

Primary Language (Please mark only one choice)	
English	2,130
Spanish	
Farsi	
Cantonese	1,112
Mandarin	87
Other Chinese Dialects	25
Vietnamese	1265
Korean	129
Tagalog	2
Other Filipino Dialect	
Japanese	14
Laotian	5
Cambodian	237
Mien	318
Hmong	
Samoan	
Thai	
Russian	
Polish	
German	
Italian	
Turkish	
Hebrew	
French	
Portuguese	
Armenian	
Arabic	
Sign ASL	
Other primary language not listed Fijiian-12 Leu-1 Mongolian-1 Other - 8	22
Unknown/ Decline to Answer	

Gender Identity (Please mark both parts A &		
A)	Assigned sex at birth: (Please mark only one choice)	
	Male	1,747
	Female	3,095
	Other sex not listed (e.g. Intersex)	423
	Unknown/Decline to Answer	
B)	Current Gender Identity: (Please mark only one choice)	
	Male	
	Female	
	Transgender	9
	Genderqueer	
	Questioning or Unsure of Gender Identity	
	Another Gender Identity not listed	
	Unknown/Decline to Answer	

Disability Status (Please mark all that apply)		
None		1,744
Yes. If yes, please specify (choose from list below):		
	Difficulty Seeing	2
	Difficulty hearing, or having speech understood	2
	Mental Domain	348
	Physical/Mobility Domain	19
	Chronic Health Condition	35
	Another disability not listed	7
Unknown/Decline to Answer		3,189

Veteran Status (Please mark only one choice)	
Yes	1
No	3,513
Unknown/Decline to Answer	5,348

Program Overview

1. What were the successes/accomplishments of the past year? Please provide one example or case study of a success your agency is particularly proud of.

First, the Prevention Program succeeded at meeting and surpassing two of its main contractual goals for FY 18-19. Through various Prevention activities throughout the FY 18-19 year, staff engaged a total of 6,012 community contacts (in excess of the 5,640 expected). Prevention staff conducted a total of 173 mental health consultation events throughout the year, when 165 events were expected.

One of the other biggest successes/accomplishments of the past year was sustaining the program's implementation of an "Introduction to Mental Health" presentation/workshop, which empowers participants to identify signs of stress and develop healthy coping strategies for stress in order to prevent more serious mental health problems. Staff developed Introduction to Mental Health using knowledge gained at a training on Dynamic Mindfulness during FY 17-18 as well as from trainings on Mental Health First Aid, and Seeking Safety training from previous years. They designed the presentation to be highly interactive and to use language and concepts accessible to everyday community members. Staff first piloted Introduction to Mental Health in the earlier months of FY 17-18 with youth audiences during outreach activities with AYPAL, one of our community partner organizations, and "in-reach" activities at AHS' The Spot, another division of AHS where several youth programs are held. Staff also conducted the workshop for students and staff at Laney College; this workshop was led in English, while Chinese and Vietnamese staff were available for interpretation as needed. Over time, Prevention staff refined the presentation based on internal discussions as well as feedback from audience members. They finalized a standard version of the presentation and translated the written presentation from English to Korean, Chinese, and Vietnamese. We were able to successfully continue this program in FY 18-19 and share our presentations with our programs doing mental health awareness presentations focusing on the API community.

2. What were the challenges and how did your agency mitigate challenges?

First, due to staff turnover in fourth quarter 2019, the program lost one Vietnamese outreach worker and our Prevention Program manager resigned. This made it more difficult to effectively outreach to these communities and find enough referrals to the Preventive Counseling program. We attempted to mitigate the loss of our Vietnamese worker by continuing to facilitate the group with other Vietnamese outreach workers and our Vietnamese MSW intern. We also shifted management responsibilities to our Division Director, Kao Saechao, and QI Manager, Shadia Gadoy, and will fill the position in August 2019 with an internal AHS candidate. We also hired an MSW intern for 10 weeks beginning in June 2019, which allowed us to further extend our outreach efforts to the Chinese community, such as translating the Introduction to Mental Health API outreach materials, tabling events, and co leading our Chinese support groups.

Second, some staff had ongoing difficulties adjusting to the EPIC Health Record System to record and adjust work flows for some Prevention activities. Staff spent a significant amount of time in starting in April through May attending EPIC trainings. One-on-one training and consultation were provided as needed to coach staff in documenting in EPIC for those who continued to struggle using the system. The staff continues to receive trainings and support.

Third, transitioning to our new East Asian UELP grant was disruptive to our overall service delivery during the 4th quarter. Our Southeast Asian (SEA) clients had to be notified of the change in our scope and service delivery and we also began transitioning our support groups and our individual consultation clients. This affected client care to some extent as some clients reported feeling "sad" and did not seek to be transitioned out to other programs.

3. Please describe the innovative ways your program has weaved the topics of mental health/emotional well-being into your activities. Please give at least one example.

Our "Walking 4 Wellness" support group continued this year to engage API community members in innovative mental health activities, primarily through light physical activity and discussion. The group was held every week, and many participants became regular attendees. Through their weekly walks, participants engaged in physical wellness activities while also being able to discuss mental health topics (such as depression or anxiety), share their experiences with one another, and support each other on their road of recovery.

Another innovative program we began this FY was incorporating our AHS NP fellows (Nurse Practitioner Fellows from AHS) to present at health and wellness workshops. These were highly popular and successful as the NP fellows were exposed to working with our API community and the community was able to interact with the NP's outside a clinic setting. This provided much needed health education, training, and activities to promote wellness amongst our API populations about their health and mental health.

4. Please describe how your program has encouraged access to your services and your strategies for successful linkage for mental health treatment.

One of our most successful strategies is to integrate our specialty mental providers in the Prevention programs. All of our Prevention program staff are trained mental health professional (Mental Health Rehabilitation Specialist (MHRS), board registered AMFT's, LCSW, MSW interns, or family partners) in our Specialty mental health treatment programs. We are able to successful engage the clients in preventative services and transition with them to specialty mental health services as needed. Most of the time, the same prevention program staff will become the client's specialty mental health treatment counselor. This helps to reduce the stigma, improve warm handoffs, and encourage access to services. Also, our Prevention programs are located in the same building as the specialty mental health treatment services. This helps client develop a familiarity and routine with visiting our clinic for services, further reducing stigma and increasing engagement.

5. Describe how your program interacted with various other ACBH funded programs/projects such as school-based programs, other prevention programs, the stigma and discrimination reduction campaign, 10 x 10 campaign etc.

One of our continued successful partnerships this year was our participation in Alameda County's annual 10 x 10 Wellness Campaign event, in Marina Park, San Leandro in May 2019. As in previous years, our Prevention Program sent representatives to the campaign's monthly Community Advisory Board meetings, so that we could be involved in the planning and coordination of the event as mental health consultants. Through our outreach and coordination, we also accomplished sending 70 (50 in the previous year) API community members already linked into our services to the all-day event, where they participated in healthy physical activities, learned about other wellness services and resources around the county, and confronted the stigma of mental health by being part of this public effort to raise mental health awareness. Finally, our program hosted one of the many community resource tables at the event. We designed an interactive engagement activity for 10 x 10 attendees who came to our table, where they were able to identify signs of stress and effective ways of coping with stress. We then shared information about our SMH Treatment and Prevention services with attendees. Through this engagement, we reached 108 unique community contacts in in San Leandro (last year 98 unique clients), representing a portion of the county that we have not outreached to often but would like to connect with more.

We participated in other prevention-related projects in the wider Alameda County BHCS system as well. As previously mentioned, we partnered with Burma Family Refugee Network to continue to facilitate a Karen adult wellness support group this past year. Another partnership we had was with Alameda County BHCS, Child and Young Adult System of Care (CYASOC), who invited us to provide mental health consultation/training to master's level interns at the Juvenile Justice Center and other CYASOC programs. Here, the Program Manager presented on the topic of intergenerational trauma in API families and other communities of color.

Through sharing this perspective developed by working with our clients, we hope that the awareness, treatment, and prevention of important issues affecting underserved API communities becomes more widespread throughout Alameda County.

Finally, the Prevention Program collaborated with various other community-based and school-based organizations by providing outreach, engagement, consultation, resource tabling, and psycho-education meant to engage low-income, underserved API community members in mental health and wellness. Some of these collaborations have been mentioned elsewhere in this report. Others include partnerships with Public Health Institute to promote the wellness of Asian Youth throughout Oakland and Alameda County; the Asian Outreach Committee of Samuel Merritt University's Ethnic Health Institute to provide mental health consultation on outreaching to Asians in the Bay Area regarding various health-related resources.

6. What are your goals for your program for the upcoming fiscal year?
- Meet our contract goals (esp. preventive counseling and consultation)
- Diversify support groups, workshop series, and large-scale outreach events to reach more community members, especially around particular relevant topics and focused on the East Asian populations
- Continue to outreach and establish a presence in Central County (building on relationships made at Moon Festival, San Leandro Library, and EHI Asian Outreach Committee)
- Continue to recruit new cultural competent Manager, staff, and interns for the program to meet the needs of our new grant.

Access & Linkage to Mental Health Treatment (Question 1 and 3 are required per your Exhibit A - Quality Measures)

1. Number of individuals with serious mental illness (SMI) or exhibit symptoms of a SMI who received a paper referral (i.e. referrals via phone do not apply) from your program…
   a. To an ACBH-funded mental health treatment program: 3
   b. To a non-ACBH-funded mental health treatment program: 0

2. List type(s) of mental health treatment programs the individual was referred to (i.e. outpatient, inpatient, etc.): Outpatient Specialty Mental Health Services

3. Number of individuals who were successfully referred and linked (i.e. client has been seen at least once in person by a treatment provider):
   a. To an ACBH mental health treatment program: 3
   b. To a non-ACBH-funded mental health treatment program: 0

4. Average duration in weeks of signs of untreated mental illness (per client self-report) *(write "n/a" or "unknown" when applicable): Within 10 Business days the clients are linked to SMH services*

5. Average time in weeks between when a paper referral was given to individual by your program and the individual's first in person appointment with a mental health treatment provider *(write "n/a" or "unknown" when applicable)*: Within 10 business days the clients are linked to SMH services

Timely Access (to other PEI-funded programs)

1. Number of separate paper referrals to another ACBH **PEI-funded** program. *(write "n/a" or "unknown" when applicable)*: 2

2. Number of individuals followed through on referral & engaged in an ACBH PEI-funded program *(write "n/a" or "unknown" when applicable)*: 2

3. Average time in weeks between when a paper referral was given to individual by your program and the individual's first in person appointment with the ACBH PEI-funded provider *(write "n/a" or "unknown" when applicable)*: Unknown

UELP Prevention Data Report FY 18/19

MHSA Program Number: PEI 6
Program Name: Outreach, Education & Consultation for Asian Pacific Islander Community - Center for Empowering Refugees and Immigrants (CERI)/Reviving Our Youth's Aspirations (ROYA)

The mission of the Center for Empowering Refugees and Immigrants (CERI) is "to improve the social, psychological, and economic health of refugee families in which one or more individuals have been affected by war trauma, genocide, torture or another form of extreme trauma." Core services include: individual, family, and group counseling; case management, advocacy, and referrals; a range of wellness and enrichment activities; and culturally-grounded community gatherings, projects, and events, on-site at CERI and in local community venues. Through its youth/young adult program, ROYA, CERI also provides services for children, teens, Transition-Age Youth (TAY), and young adults, designed to address the intergenerational impact of war trauma and empower young people from the CERI community who are at risk for becoming involved in crime, drugs, violence, and sexual exploitation.

General Information & Total Numbers Served

Total Numbers Served through PEI MHSA		
Number of unduplicated individuals your program serves who are **at-risk** of developing a mental health problem or serious mental illness (SMI)	A	6,443
Number of unduplicated individuals your program serves who show **early signs** of forming a more severe mental illness	B	25
Number of unduplicated individual family members served indirectly by your program:	C	
Grand TOTAL of unduplicated individuals served in the Quarter that you are reporting about. [This number (D) should = A+B+C.]	D	6,468

DEMOGRAPHICS

Age Group (Unduplicated)	
Children/Youth (0-15)	371
Transition Age Youth (16-25)	947
Adult (26-59)	3,451
Older Adult (60+)	1,490
Unknown/ Declined to Answer	194

Race (Please mark only one choice) *If Hispanic or Latino, choose "Another race not listed."*	
American Indian or Alaska Native	16
Asian	5,379
Black or African American	156
Native Hawaiian or other Pacific Islander	3
White	210
More than one race	79
Another race not listed	320
Unknown/ Declined to Answer	266

Sexual Orientation (Please mark only one choice)	
Gay or Lesbian	130
Heterosexual or Straight	4385
Bisexual	19
Questioning or unsure of sexual orientation	8
Queer	326
Another sexual orientation not listed	40
Unknown/Decline to Answer	1528

Ethnicity /Cultural Heritage (Please mark only once choice)	
If Hispanic or Latino, please specify:	
Caribbean	
Central American	
Mexican/Mexican--American/Chicano	
Puerto Rican	
South American	
Another Hispanic/Latino ethnicity not listed	286
Unknown/Declined to Answer	
If Non-Hispanic or Non-Latino, please specify:	
African	
African American	
Asian Indian/South Asian	8
Cambodian	4,709
Chinese	68
Eastern European	
European	
Filipino	
Japanese	17
Korean	6
Middle Eastern	
Vietnamese	108
Other Non-Hispanic or Non-Latino ethnicity not listed Fijian - 44 Afghan - 40 Pacific Islander – 3 Indonesian – 20 Lao – 3 Nepalese- 46 Persian Iranian – 78 Thai – 11 Other South East Asian – 49 Other Indigenous – 18 Taiwanese - 3	315
More than one ethnicity	
Unknown /Declined to Answer	

Primary Language (Please mark only one choice)	
English	2,291
Spanish	49
Farsi	19
Cantonese	
Mandarin	
Other Chinese Dialects	
Vietnamese	39
Korean	2
Tagalog	
Other Filipino Dialect	
Japanese	
Laotian	
Cambodian	3,923
Mien	
Hmong	
Samoan	
Thai	
Russian	
Polish	
German	
Italian	
Turkish	
Hebrew	
French	
Portuguese	
Armenian	
Arabic	11
Sign ASL	
Other primary language not listed Hindi – 6 Persian – 30 Punjabi – 5 Other - 66	107
Unknown/ Decline to Answer	

Gender Identity (Please mark both parts A &	
A) Assigned sex at birth: (Please mark only one choice)	
Male	1,608
Female	4,386
Other sex not listed (e.g. Intersex)	
Unknown/Decline to Answer	213
B) Current Gender Identity: (Please mark only one choice)	
Male	
Female	
Transgender	106
Genderqueer	
Questioning or Unsure of Gender Identity	
Another Gender Identity not listed	
Unknown/Decline to Answer	6,337

Disability Status (Please mark all that apply)	
None	2,430
Yes. If yes, please specify (choose from list below):	
Difficulty Seeing	13
Difficulty hearing, or having speech understood	12
Mental Domain	2,786
Physical/Mobility Domain	84
Chronic Health Condition	43
Another disability not listed	8
Unknown/Decline to Answer	

Veteran Status (Please mark only one choice)	
Yes	0
No	5,749
Unknown/Decline to Answer	649

PROGRAM OVERVIEW

1. What were the successes/accomplishments of the past year? Please provide one example or case study of a success your agency is particularly proud of.

   Over the past year, CERI had notable successes and accomplishments in three key areas:

YOUTH/YOUNG ADULT SERVICES:
CERI expanded its services for at-risk youth and young adults in three ways. First, it launched a Co-Ed Support Group facilitated by a second-generation Cambodian American staff member, age 35.

Currently, 14 youth and young adults (ages 16-22) participate in the weekly group, which focuses on both leadership and advocacy skills and emotional support. The participants in this group also created CERI's new youth-led Youth Development Team, which meets regularly with the City of Oakland's Equity and Race Initiative team. Finally, in response to the local need for LGBTQ services specifically for Southeast Asians, CERI now provides a drama therapy group with a social justice focus, as well as individual therapy as needed, for up to 20 Southeast Asian LGBTQ young adults (ages 18 to 30), facilitated by an MFTI from the LGBTQ Southeast Asian community. The group has been instrumental in providing support in combating stigma, homelessness, prevention of major mental illness, and even suicidal ideation among this vulnerable population of young people as they explore their sexual identity in the context of their own culture and society at large.

ADULT/OLDER ADULT SERVICES:
CERI continues to provide clinical services, support groups, care management, and community activities for its adults and older adults, who were most directly impacted by the Khmer Rouge genocide. Over the last year, it has continued its Drama Therapy group for adult survivors, which has helped empower them to tell their story and achieve a new level of healing. CERI has also hired a new Cambodian American interpreter and care manager, who helped revive the women's groups. As a result, the number of individuals participating in these support groups has increased and more elders are taking a leadership role in the community. For many, this ongoing support has been life changing, as in the case of V. below.

Case Study of V.:
One of CERI's clients, V., a 59-year-old female who, in the past, had been sexually abused and sold into prostitution, was suicidal with plans. When she first came to CERI, she had severe Post-Traumatic Stress Disorder (PTSD), major depression, and persistent flashbacks about what had happen to her and her family during the Cambodian genocide. At CERI she received individual therapy and psychiatric treatment and, over time, started to come to support groups and participate in community activities, such as dance and potluck parties, field trips and camping. She also became the leader in community garden program. Recently, V., who now has no suicidal ideation, spoke at a public event about her experience as a refugee. She had been interviewed with a writer and her story is going to be a chapter in a book about refugees. Although she still gets some flashbacks and dreams about the past, they are now about her childhood memories before war. She remembers things she forgot long time ago. She recently told the CERI staff that "Life is a beautiful thing" and that "she wants to live."

FUNDRAISING: One of CERI's goals last year was to expand and diversify its funding. CERI made great progress toward this goal, receiving support from the Devata Giving Circle, the Episcopal program funds, and Beacon funding. It also got two grants from the City of Oakland, for youth leadership and a written word workshop for teenagers and adults, led by a Cambodian American writer. It is currently working with clients to plan a major fundraising/cultural event this fall to mark the 40th Anniversary of the end of the reign of the Khmer Rouge.

2. What were the challenges and how did your agency mitigate challenges?

CERI faced two main challenges over the past year:
1) Safety issues related to its youth program expansion; and,
2) ICE raids and deportations impacting the Cambodian refugee community.

CHALLENGE #1: SAFETY ISSUES RELATED TO EXPANDED YOUTH SERVICES

One of the positive aspects of CERI's expanded youth services is that it brought more teens and young adults into CERI to engage in services.

This also raised safety concerns, as many of these young people have been involved in gangs, drug dealing, and the sex trade. CERI's adult clients voiced concerns about keeping CERI a safe place for the community to meet. CERI addressed this issue by engaging in community conversations to establish new ground rules for the CERI community (i.e., no drugs, alcohol, smoking, weapons, violence, stealing, or solicitation), preventative work, and restorative justice practices. Participating youth and young adults made a verbal commitment to respect these rules. CERI also created a new front desk position to monitor youth activities, run by a former member of the youth program who has a criminal past but has since turned her life around and can serve as a role model and resource for these youth.

CHALLENGE #2: ICE RAIDS AND DEPORTATION

February 2019 marked the beginning of ICE raids that would devastate the Cambodian community, tearing families apart. Several CERI community members were targeted for deportation—mostly individuals now in their 40s, born in Cambodia or resettlement camps, who, here in the U.S., had acquired a criminal record as teens or young adults.

CERI addressed this crisis by holding a community meeting on March 6, 2019, co-hosted with the Asian Law Caucus (ALC) and the Asian Prisoner Support Committee (APSC), two local advocacy organizations dedicated to helping impacted individuals fight deportation. This was the first collaboration of this kind for CERI, which joined the anti-deportation efforts and offered emotional support to clients and loved ones impacted while the collaborating organizations held the legal and political organizing pieces. As a result of this meeting, CERI started a series of Impacted Families Support Sessions, to help hold space for family members as they navigated this emotional journey.

On March 13th, the CERI, APSC, and ALC communities came together to rally and support individuals who were scheduled to turn themselves in, protesting at the ICE office in San Francisco. Over the next couple of months, CERI elders were introduced to education around deportation policies, in order to understand their rights and know what needed to happen legally for people to be able to stay. They learned how to lobby, visiting legislators in Sacramento, and became more empowered and politicized to be able to share their own narratives and how Cambodian deportations were affecting the community. CERI staff also provided psychological evaluations, which were submitted to the judges.

After months of intense organizing, the four members of the CERI community who had been targeted got their convictions vacated or were pardoned by the Governor and their deportation orders were rescinded—an amazing feat. The attorneys involved said that if it were not for the active involvement of CERI's clients these individuals would not have been pardoned. Unfortunately, 37 other Cambodian Americans from California and the rest of the country were deported in early July. CERI plans to continue its partnership with ALC and APSC, as more ICE raids are expected.

CERI will continue to provide ongoing support for clients around this issue to address the heightened fear generated by the deportation raids, which triggered reactivation of PTSD symptoms. This type of mental health and wellness support is particularly important for highly-traumatized genocide survivors.

3. Please describe the innovative ways your program has weaved the topics of mental health/emotional well being into your activities. Please give at least one example.

During the FY 2018-2019 UELP contract period, CERI continued to pursue innovative ways to expand its grassroots, community-based mental health model to support the mental health and emotional well-being of its clients:

YOUTH LEADERSHIP COMPONENT:
In addition to expanding services for youth and young adults and establishing related safety policies and strategies, CERI recruited Cambodian Americans from similar backgrounds to serve as role models for the youth.

These include: 1) a former CERI youth program member turned staff member (for five years) who had turned her life around (i.e., finishing high school, completing her AA degree) after engaging in various crimes as a teen, now serves as the front desk person and monitors youth activities; and, 2) a former gang member, who now co-facilitates the new Co-Ed Support Group for youth and young adults and educates them about the realities of incarceration and the criminal justice system.

LGBTQ COMPONENT: Through CERI's new Southeast Asian LTBTQ support services—among the first services of this kind in the county—CERI has begun to raise awareness about and reduce stigma around being gay, which has been a taboo topic in the Southeast Asian community. As a result, one Cambodian American staff member has since "come out" as gay, and as many as 20 youth and young adults primarily Cambodian American, have sought support and been empowered.

DRAMA THERAPY: Over the last year, CERI has continued to use Drama Therapy/Expressive Arts Therapy as an innovative approach for highly-traumatized and largely non-English speaking Cambodian refugees to process their experience during the Cambodian genocide and reach a deeper level of healing. To support this innovation, all CERI clinical staff members have undergone at three-month training in using Drama Therapy to therapeutic tool for healing trauma, taught by an expert in the field.

ANTI-DEPORTATION ADVOCACY AND SUPPORT:
Through CERI's recent anti-deportation work, CERI's adult and older adult clients have been empowered to learn their rights and play a role in protecting their families and community. CERI provide emotional support services for families facing the possible deportation of a loved one. CERI also prepared psychological evaluations for the four CERI community members targeted, for use in pleading their court case.

CIVIC EDUCATION AND ADVOCACY:
The anti-deportation work is part of a larger effort within CERI to provide civic education, information, and advocacy training for its clients to help them move from isolation to engagement in issues affecting their community. In response to proposed government cutbacks in food stamps, for example, CERI has helped clients, who are all SSI recipients, to register with CalFresh, in order to feed their families. CERI has also worked with clients to help them to register to vote, understand the ballot, and educate themselves about their rights in American society. This is particularly important for these clients, as under the Khmer Rouge regime, they did not have any rights or freedom of expression and taking a stand could lead to imprisonment, torture, or death for them and their family.

SUPPORT SYSTEM FOR FAMILIES:
Finally, CERI has recently introduced a new support feature for impacted family families. Now every Tuesday, from 4 to 6 pm, CERI holds family nights. Parents and couples and can get individual, family therapy and group support while their children engage in play therapy.

YOGA FOR TRAUMA SURVIVORS:

This year CERI added an additional offering to its wellness menu: Yoga for Trauma Survivors. Held on-site at CERI's center, this weekly class focuses on gentle yoga movement designed to help trauma survivors reconnect with their body and begin to process long-held emotions from past traumatic experiences. CERI clinical staff members are on hand to help support clients in addressing any emotions that may arise. CERI staff members also have their own restorative yoga class on-site to address self-care and prevent staff burnout and increase staff resiliency and retention.

4. Please describe how your program has encouraged access to your services and your strategies for successful linkage for mental health treatment.

ACCESS TO SERVICES:

CERI's primary strategy for creating access is to provide culturally and linguistically appropriate clinical services within the context of a community center (vs. medical office) setting. CERI's center is designed to be warm and welcoming and open to all. The waiting room resembles a comfortable living room, providing an inviting space for people to come in, have coffee and tea, meet others, and get the help they need. The center also has larger rooms for social gatherings and celebrations, dance classes, support groups, and wellness programs, along with two kitchens in which clients can cook and prepare communal meals. CERI has now become known throughout the local Cambodian community as a safe and supportive resource.

During the hours of operation, CERI always has a Khmer-speaking staff member available to provide services in Khmer and English. Trained interpreters from the community assist with confidential individual, family, and group therapy sessions, and referrals, as needed.

In addition to its on-site services, CERI also conducts about 20-25 percent of its services out in the community. CERI staff members regularly make home visits to meet with CERI families. CERI also maintains a heavy care management workload as, whenever a client is referred to a service, CERI usually follows up by helping clients set the appointment and accompanying them to the appointment. This entails going with a client to a medical appointment (with an interpreter, as needed), working with clients to help resolve SSI, MediCal, housing, immigration, and/or legal issues, and helping them navigate social services and school, and legal systems.

REFERRALS:

CERI also provides referrals (psychiatric, medical, legal, housing, social services, etc.) to clients, as needed. To support its ability to connect clients with needed services, CERI maintains strong partnerships with a range of community-based organizations (CBOs) and school-based programs. Ongoing community partners include: Asian Health Services, Bay Area Community Services (BACS), Bay Area Legal Aid, Banteay Srei, Homeless Action Center, and La Clinica San Antonio Health Services.

CERI also works with local law enforcement and county mental health providers, as needed, to support clients in crisis. In a recent example, a young woman, second generation Cambodian American, who is schizophrenic, became increasingly isolated and stopped taking her medication.

When the police were called to her home to intervene in a domestic dispute, CERI was able to work with them to advocate for psychiatric emergency services. She was taken to a psychiatric emergency ward, hospitalized for one week and then spent two weeks at Woodroe Place, a local crisis stabilization residential program operated by the Bay Area Community Services (BACS). While in that program, she participated in family therapy sessions with CERI staff to develop a safety plan so that she could go home. After her release, CERI worked with county services to connect her to a Level 1 service team so that she could get follow-up care management and psychiatric services. She is now stabilized and doing well.

5. Describe how your program interacted with various other ACBH funded programs/projects such as school-based programs, other prevention programs, the stigma and discrimination reduction campaign, 10 x 10 Campaign, etc.

CERI interacts with other ACBH programs/projects in several ways. In terms of school-based programs, CERI works closely with counseling programs at various Oakland public schools to help CERI youth clients navigate issues that arise in the school setting and help these young clients to stay in school.

CERI also supports ACBH's commitment to ensuring that underserved populations—particularly refugees and asylees—in Alameda County have access to mental health and wellness services.

To this end, CERI is actively partnering and exploring projects with other community-based groups serving the local Southeast Asian population to see how it can strengthen its own model and expand it to other underserved populations. These include: Asian Refugees United (ARU), which works with LGBTQ individuals and elders in the Vietnamese and Bhutanesen refugee communities; Banteay Srei, which serves as a resource for Southeast Asian young women at risk for sexual exploitation; Burma Refugee Family Network, which serves the local Burmese refugee community.

This past year CERI has been much more involved with other UELP providers, including the Korean Community Center of the East Bay (KCCEB), Filipino Advocates, Hume Center and Partnership for Trauma Recovery (PTR). These collaborations have coordination around service delivery and best practices, advocacy around language-specific services for different populations, and joint planning for the upcoming U.S. Census.

Through its Wellness in Action program, CERI also facilitates a monthly professional development group for UELP providers, to support one another in working with highly traumatized refugee populations. All of the group participants are from the same background as the population that their agency serves and, therefore, must continue to learn healthy ways to deal with their own trauma while serving this population.

CERI has also partnered with the Asian Law Caucus (San Francisco) and the Asian Prisoners Support Committee (Oakland) to protect the legal rights of clients in relation to deportation issues. CERI has also partnered with the City of Oakland Equity and Race Initiative to foster youth leadership development and involvement around equity issues and continued to work with ARU around stigma reduction in the Southeast Asian community. Finally, CERI participates in BHCS's 10 x 10 campaign, which is designed to reduce disparities for individuals with mental health challenges, by organizing rides and providing transportation stipends for clients to attend public health walks and fairs and other related community events.

6. What are your goals for your program for the upcoming fiscal year?

CERI has five interrelated goals for the upcoming fiscal year (FY 2019-2010):

1. **STRENGTHENING COMMUNITY-BASED MENTAL HEALTH AND WELLNESS SERVICES**: Continue to build its capacity to serve the current and emerging needs of its multigenerational client population through expanded services and wellness programs (i.e., specialized support groups; Drama Therapy; stigma reduction campaigns; services for youth and young adults; services for the Southeast Asian LGBTQ community, etc.), delivered in a culturally sensitive and linguistically appropriate manner.

2. **EXTENDING THE CERI MODEL COUNTYWIDE:** Over the next year, CERI plans to work with other UELP providers and community-based organizations to extend the CERI model to other Southeast Asian refugee and asylee populations through on-site and off-site services, advocacy, community events, and strategic partnerships.

3. **EMPOWERING CLIENTS THROUGH CIVIC EDUCATION AND ADVOCACY:** CERI will continue to collaborate with community partners to provide leadership and advocacy training, information, and emotional support for clients, to help them engage in civic issues, learn about their rights, and protect their community, with a focus on the upcoming U.S. Census campaign.

4. **EXPANDED SERVICES FOR YOUNGER CHILDREN:** CERI will also focus on expanding its services through children in the CERI community using play, Expressive Arts/Drama Therapy, visual arts, and basic Khmer language learning.

5. **SUSTAINABILITY:** Diversify and expand funding sources to sustain and grow CERI's program over the next five years.

ACCESS & LINKAGE TO MENTAL HEALTH TREATMENT (QUESTION 1 AND 3 ARE REQUIRED PER YOUR EXHIBIT A - QUALITY MEASURES)

1. Number of individuals with serious mental illness (SMI) or exhibit symptoms of a SMI who received a paper referral (i.e. referrals via phone do not apply) from your program
   a. To an ACBH-funded mental health treatment program: 1
   b. To a non-ACBH-funded mental health treatment program: 2 (not paper referrals)

2. List type(s) of mental health treatment programs the individual was referred to (i.e. outpatient, inpatient, etc.):
   PES, in- patient, crisis stabilization, outpatient level 1 services team
   Outpatient Mental health services- non ACBH, no paper trail

3. Number of individuals who were successfully referred and linked (i.e. client has been seen at least once in person by a treatment provider):
   a. To an ACBH mental health treatment program: 1
   b. To a non-ACBH-funded mental health treatment program: 2

4. Average duration in weeks of signs of untreated mental illness (per client self-report) *(write "n/a" or "unknown" when applicable):* Unknown

5. Average time in weeks between when a paper referral was given to individual by your program and the individual's first in person appointment with a mental health treatment provider *(write "n/a" or "unknown" when applicable)*: client was seen the day of referral due to crisis.

TIMELY ACCESS (TO OTHER PEI-FUNDED PROGRAMS)

1. Number of separate paper referrals to another ACBH PEI-funded program. *(write "n/a" or "unknown" when applicable)*:
   This year we did not do paper referrals to other PEI funded programs, however we made phone referrals for 8 to 10 clients to other PEI programs including Partnership for Trauma Recovery, Hume Center, and Asian Health Services.

2. Number of individuals followed through on referral & engaged in an ACBH PEI-funded program *(write "n/a" or "unknown" when applicable)*: Unknown

3. Average time in weeks between when a paper referral was given to individual by your program and the individual's first in person appointment with the ACBH PEI-funded provider *(write "n/a" or "unknown" when applicable)*: Unknown

UELP Prevention Data Report FY 18/19

MHSA Program Number: PEI 6
Program Name: Outreach, Education & Consultation for Asian Pacific Islander Community - Community Health for Asian Americans (CHAA)

Asian Pacific Islander Connections (APIC)/UELP program has offered a full continuum of community-driven, Prevention and Early Intervention services for underserved Asian Americans Immigrants and refugee populations. Such as Burmese, Karen, Thai, Tibetan, Mongolian, Tibetan, Nepalese, Bhutanese, Pacific Islanders. APIC celebrated its 9th year of providing services.

This includes expansion of prevention /early intervention, outreach, education, Medi-Cal outreach, spiritual and cultural healing services, community-driven partnerships, language/translation services, including case management.

General Information & Total Numbers Served

Total Numbers Served through PEI MHSA		
Number of unduplicated individuals your program serves who are **at-risk** of developing a mental health problem or serious mental illness (SMI)	**A**	1,862
Number of unduplicated individuals your program serves who show **early signs** of forming a more severe mental illness	**B**	
Number of unduplicated individual family members served indirectly by your program:	**C**	
Grand TOTAL of unduplicated individuals served in the Quarter that you are reporting about. [This number (D) should = A+B+C.]	**D**	1,862

DEMOGRAPHICS

Age Group (Unduplicated)	
Children/Youth (0-15)	214
Transition Age Youth (16-25)	218
Adult (26-59)	1,309
Older Adult (60+)	91
Unknown/ Declined to Answer	30

Race (Please mark only one choice) *If Hispanic or Latino, choose "Another race not listed."*	
American Indian or Alaska Native	
Asian	1,828
Black or African American	2
Native Hawaiian or other Pacific Islander	24
White	6
More than one race	
Another race not listed	
Unknown/ Declined to Answer	2

Sexual Orientation (Please mark only one choice)	
Gay or Lesbian	17
Heterosexual or Straight	1,733
Bisexual	
Questioning or unsure of sexual orientation	
Queer	
Another sexual orientation not listed	
Unknown/Decline to Answer	112

Gender Identity	
A) Assigned sex at birth: (Please mark only one choice)	
Male	649
Female	1,187
Other sex not listed (e.g. Intersex)	
Unknown/Decline to Answer	26
B) Current Gender Identity: (Please mark only one choice)	
Male	
Female	
Transgender	
Genderqueer	
Questioning or Unsure of Gender Identity	
Another Gender Identity not listed	
Unknown/Decline to Answer	1,862

Primary Language (Please mark only one choice)	
English	41
Spanish	
Farsi	
Cantonese	
Mandarin	
Other Chinese Dialects	
Vietnamese	
Korean	2
Tagalog	
Other Filipino Dialect	
Japanese	
Laotian	
Cambodian	
Mien	
Hmong	
Samoan	
Thai	
Russian	
Polish	
German	
Italian	
Turkish	
Hebrew	
French	
Portuguese	
Armenian	
Arabic	
Sign ASL	
Other primary language not listed Burmese - 86 Genapali – 15 Karen – 13 Karenni – 2 Mon -3 Mongolian – 1391 Rakhaing - 7 Thai – 226 Tibetan – 44 Tongan – 28 Other – 2	1,817
Unknown/ Decline to Answer	

Disability Status (Please mark all that apply)	
None	1,573
Yes. If yes, please specify (choose from list below):	
Difficulty Seeing	2
Difficulty hearing, or having speech understood	
Mental Domain	1
Physical/Mobility Domain	1
Chronic Health Condition	3
Another disability not listed	
Unknown/Decline to Answer	281

Veteran Status (Please mark only one choice)	
Yes	
No	1,627
Unknown/Decline to Answer	235

PROGRAM OVERVIEW

1. What were the successes/accomplishments of the past year? Please provide one example or case study of a success your agency is particularly proud of.

We successfully provided resources to clients and implemented families strengthening programs to reduce stress and to cope with the challenges of life events. We provided individual consultation and educational resources and linked them to referral services based on the need of the clients.

Majority of our EI clients are survivors of domestic violence and war and PTSD. Currently, domestic violence and other abuses are affecting API communities. 1/3 of all APIC's Early intervention clients are experiencing domestic violence and or other forms of violence/ issues.

We are particularly proud of the case management services and Domestic Violence/ Trauma-Informed Care services that were rendered to domestic violence (DV) clients who needed emergency services including shelter, food, transportation, interpretation and translation services, legal referrals, and mental health and family therapy and job placement. For example: we assisted a homeless client who faced many discriminations from within the community and suffered from DV and PTSD. We also referred this client for legal services to assist with court proceedings and created a support group for healing and social connectivity to help the client integrate into the mainstream society. As a result, of the services that we are provided the client was able to secure employment and become self-sufficient.

2. What were the challenges and how did your agency mitigate challenges?

The challenge has been the lack of sustainable funding for UELP program, which affected staff morale and uncertainty about adequately addressing the need of community. Despite the funding challenges we continue to provide services to all our clients by leveraging resources within the community. For example, we created traditional and spiritual healing by working with local CBO's and faith and traditional healers. As such, we have been able to provide culturally competent services to clients with limited funding sources.

3. Please describe the innovative ways your program has weaved the topics of mental health/emotional well-being into your activities. Please give at least one example.

Mental and behavioral services have many challenges, especially systemic challenges and stigma in API communities about seeking mental health support. We have developed a collaborative care model that incorporates mindfulness based on traditional healing model. We encouraged faith and spiritual healers to understand mental health issues and to provide mindfulness and yoga model and to work with our clients.

APIC staff organized the Mental Health and Spirituality and traditional healing event. This became very popular within the community as more clients and community members sought the services that we provided, which has increased the number of clients we serve.

4. Please describe how your program has encouraged access to your services and your strategies for successful linkage for mental health treatment.

In order to provide enhance access to our services, we engaged in extensive outreach and organized a wide variety of workshops, events and support groups. Community-based approaches to enhance access mental health; enhance access and continuity, culturally and linguistic appropriate services, culturally appropriate

communication, client need based support and care, referral and follow-up, coordinate care coordination, continues quality improvement.

All these activities were designed to target community members who faced enormous barriers to gaining access to mental health services. In addition, we targeted individuals and families who were struggling emotionally, financially or legally. We wanted to ensure that through effective case management, services were provided in a coordinated manner with our clinical program and other providers to meet the needs of the clients.

Our strategies for successful linkage for mental health treatment included educating the communities on critical issues related to trauma. Some of the issues involved immigration problem, family conflict, legal, employment, language barriers, and problems related to cultural integration in a new country. As such, we were able to provide prevention and early intervention services which included screening assessment, linkage to resources and treatment. Additionally, we translated mental health related educational materials in their language for the various populations that we serve. Moreover, we ensure that client had access to their own traditional and spiritual healing practices.

5. Describe how your program interacted with various other ACBH funded programs/projects such as school-based programs, other prevention programs, the stigma and discrimination reduction campaign, 10 x 10 campaign etc.

During the 2018-2019 fiscal year, we highlighted the importance of addressing mental health disparities and reducing health inequities in our community. This was achieved through a comprehensive partnerships with community based organizations, schools and mental health partner agencies. For example: we collaborated with PEERS, La Clinical, Native Americans Health Center and culturally responsive community-based organizations to deliver stigma reduction campaign, workshops, trainings.

6. What are your goals for your program for the upcoming fiscal year?

Our overarching goal is to ensure that clients will continue to receive critically needed services for their mental health and emotional wellbeing. Because of the long-standing relationships we have built between the community and our staff, we want to ensure that our program will continue to thrive. Our final goal is for our communities to be treated with dignity, respect, and without discrimination.

ACCESS & LINKAGE TO MENTAL HEALTH TREATMENT (QUESTION 1 AND 3 ARE REQUIRED PER YOUR EXHIBIT A - QUALITY MEASURES)

1. Number of individuals with serious mental illness (SMI) or exhibit symptoms of a SMI who received a paper referral (i.e. referrals via phone do not apply) from your program:
   8 clients total.

a. To an ACBH-funded mental health treatment program: 3

b. To a non-ACBH-funded mental health treatment program: 5
   List type(s) of mental health treatment programs the individual was referred to (i.e. outpatient, inpatient, etc.):
   John George Hospital
   Native American Health Center
   Stanford Neurological Department then to Boston Behavioral Health
   UCSF Mental Health Department

Kaiser Permanente Psychiatric Department Oakland and Concord
Kaiser Permanente Richmond Psychiatric Department (one Client)
Mindfulness and Traditional Healing Alodaw Pyi Monastery (Newark)
CHAA clinical program, therapists
Asian Community Mental Health
Regional Center in San Leandro

3. Number of individuals who were successfully referred and linked (i.e. client has been seen at least once in person by a treatment provider):

a. To an ACBH mental health treatment program: 3
b. To a non-ACBH-funded mental health treatment program: 4

4. Average duration in weeks of signs of untreated mental illness (per client self-report) *(write "n/a" or "unknown" when applicable):* Stigma, shame, embarrassment, as well as the inability to seek help. Some clients seek help after several weeks.

5. Average time in weeks between when a paper referral was given to individual by your program and the individual's first in person appointment with a mental health treatment provider *(write "n/a" or "unknown" when applicable)*: Some providers 2 weeks or less. But we advocate on behalf of our clients to get services.

TIMELY ACCESS (TO OTHER PEI-FUNDED PROGRAMS)

1. Number of separate paper referrals to another ACBH PEI-funded program. *(write "n/a" or "unknown" when applicable)*: CHAA clinical program and Native American Health Center

2. Number of individuals followed through on referral & engaged in an ACBH PEI-funded program *(write "n/a" or "unknown" when applicable)*: 7 individuals

3. Average time in weeks between when a paper referral was given to individual by your program and the individual's first in person appointment with the ACBH PEI-funded provider*(write "n/a" or "unknown" when applicable)*: 2 weeks

UELP Prevention Data Report FY 18/19

MHSA Program Number: PEI 6
Program Name: Outreach, Education & Consultation for Asian Pacific Islander Community - Korean Community Center of the East Bay (KCCEB)- Asian Community Wellness Program

KCCEB Asian Community Wellness Program: ACWP provides culturally competent and responsive programming on mental health to marginalized communities, with a focus on East Asian (Chinese, Japanese, Korean and Mongolian) population. The goal is to reduce mental health stigma, improve awareness of mental health issues facing Asians, and increase mental health service access to those that historically had difficulty accessing mental health support due to cultural and/or linguistic barriers. We serve individuals, families, and seniors in English, Korean, and Chinese language.

General Information & Total Numbers Served

Total Numbers Served through PEI MHSA		
Number of unduplicated individuals your program serves who are **at-risk** of developing a mental health problem or serious mental illness (SMI)	A	2,068
Number of unduplicated individuals your program serves who show **early signs** of forming a more severe mental illness	B	34
Number of unduplicated individual family members served indirectly by your program:	C	
Grand TOTAL of unduplicated individuals served in the Quarter that you are reporting about. [This number (D) should = A+B+C.]	D	2,102

DEMOGRAPHICS

Age Group (Unduplicated)	
Children/Youth (0-15)	155
Transition Age Youth (16-25)	155
Adult (26-59)	782
Older Adult (60+)	909
Unknown/ Declined to Answer	67

Race (Please mark only one choice) *If Hispanic or Latino, choose "Another race not listed."*	
American Indian or Alaska Native	3
Asian	1,573
Black or African American	69
Native Hawaiian or other Pacific Islander	1
White	105
More than one race	2
Another race not listed	106
Unknown/ Declined to Answer	209

Sexual Orientation (Please mark only one choice)	
Gay or Lesbian	9
Heterosexual or Straight	1,007
Bisexual	2
Questioning or unsure of sexual orientation	
Queer	17
Another sexual orientation not listed	
Unknown/Decline to Answer	1,033

Ethnicity /Cultural Heritage (Please mark only once choice)	
If Hispanic or Latino, please specify:	
Caribbean	
Central American	
Mexican/Mexican--American/Chicano	
Puerto Rican	
South American	6
Another Hispanic/Latino ethnicity not listed	89
Unknown/Declined to Answer	
If Non-Hispanic or Non-Latino, please specify:	
African	
African American	
Asian Indian/South Asian	
Cambodian	36
Chinese	293
Eastern European	
European	
Filipino	18
Japanese	6
Korean	1,005
Middle Eastern	
Vietnamese	36
Other Non-Hispanic or Non-Latino ethnicity not listed Afghan – 7 Asian Pacific Islander – 46 Indonesian – 2 Mongolia -2 Malaysian – 2 Nepalese – 14 Pakistani – 4 Samoan – 1 Taiwanese – 4 Thai – 4 Other South Asian – 3 Other Southeast Asian – 1	90
More than one ethnicity	
Unknown /Declined to Answer	

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

Primary Language (Please mark only one choice)	
English	685
Spanish	56
Farsi	19
Cantonese	123
Mandarin	106
Other Chinese Dialects	
Vietnamese	11
Korean	939
Tagalog	
Other Filipino Dialect	
Japanese	1
Laotian	
Cambodian	
Mien	
Hmong	
Samoan	
Thai	
Russian	
Polish	
German	
Italian	
Turkish	
Hebrew	
French	
Portuguese	
Armenian	
Arabic	
Sign ASL	
Other primary language not listed Bengali-1 Genpali – 15 Hindi – 1 Indonesian – 2 Kachin – 1 Karen – 7, Other - 87	115
Unknown/ Decline to Answer	

Gender Identity (Please mark both parts A & B)	
A) Assigned sex at birth: (Please mark only one choice)	
Male	701
Female	1,245
Other sex not listed (e.g. Intersex)	
Unknown/Decline to Answer	111
B) Current Gender Identity: (Please mark only one choice)	
Male	
Female	
Transgender	8
Genderqueer	
Questioning or Unsure of Gender Identity	
Another Gender Identity not listed	
Unknown/Decline to Answer	2,060

Disability Status (Please mark all that apply)	
None	907
Yes. If yes, please specify (choose from list below):	
Difficulty Seeing	
Difficulty hearing, or having speech understood	1
Mental Domain	
Physical/Mobility Domain	45
Chronic Health Condition	2
Another disability not listed	
Unknown/Decline to Answer	1,113

Veteran Status (Please mark only one choice)	
Yes	4
No	733
Unknown/Decline to Answer	1,331

PROGRAM OVERVIEW

1. What were the successes/accomplishments of the past year? Please provide one example or case study of a success your agency is particularly proud of.

This was KCCEB's inaugural year in the UELP Program, Asian Community Wellness Program. The major success for us was in creating a new mental health program from the ground up including finding staff, developing forms and protocols, partner outreach, and meeting all the county deliverables.

Staffing: Our contract began in Sept -Quarter 2 (Sept-Dec) and was focused on finding the right staffing for the program. We were able to find a bilingual English/Korean and bilingual English/Mandarin staff and a bilingual English/Portugese staff specializing in working with undocumented Asian young people. While we were able to find these staff by October, a major challenge was finding the licensed clinician for our program. This is a critical role as this person has the expertise to develop the one-on-one mental health components for the team. By December, we hired Pysay Phinith, LCSW, a seasoned API mental health clinician who has experience with the County's PEI programming. It should be noted to the County that first-time UELP contractors need more time and thus reduced deliverables for the first year. While the County did reduce the deliverables based on the fact that we started in Sept rather than July, it is appropriate to also take into consideration on-boarding, developing relationships with partners, all of which take time. While agencies have trusted relationships with the community, mental health is a stigmatizing topic and more time is needed for communities to understand the mental health services and see themselves in need and for organizational partnerships to build.

Forms and Protocols: KCCEB developed protocols and forms for one-on-one mental health preventive services and outreach materials including program flyers and mental health topic flyers in English, Chinese and Korean.

Partner Outreach: A large component of our work in Quarter 2 and 3 involved developing referral relationships and networks with partners including schools, senior centers, youth programs and other agencies that work with East Asian populations. These were critical in helping us to find referrals for our preventive counseling work. After Year 1, our most successful referral partnerships included working with high schools to see East Asian and other youth of color.

We met all deliverables: Some are highlighted below

Support Groups: Our two support groups included Jikimee Senior Leadership Group and undocumented youth support group with ASPIRE. The Jikimee group met for two quarters (15 weeks + 11 weeks) with a total of 9 - 12 participants. These seniors learned about basic mental health topics including self-care and wellness practices, stress and coping, leadership skills and learning how to be an active listener and supporter, learning about the mental health needs of the Korean community, and learning how to be a community volunteer.
Over the program, participants have gained the power to strengthen their community and personal life goals. This support group concentrated on awareness of the mental health and then moved into the practice of how to become a strong leader of the Korean community. Throughout the session, Jikimee members created their own safe and protected space in which they naturally shared personal stories. Therefore, we were able to ascertain the mental state of each other by awakening to the Korean and Asian cultural myths and stereotypes of mental health illness. The Jikimee group learned how to raise their voice to society and how to support others. This group continues to keep practicing their leadership with diverse generations and as well as future support group participants, the potential community leaders. The group is currently in training for how to be a volunteer in the organization for community health and mental health.

The ASPIRE group met on a monthly basis with an average number of 10 participants per meeting. In these meetings, most of the discussion focused on the policies impacting the overall well-being of undocumented communities such as the proposed public health rule change and expanding Medi-Cal access to all Californians regardless of immigration status. The goal was to educate ASPIRE members of what was happening around these policies to ease the anxiety that might be associated with anything related to immigration. Activities including interactive workshops breaking down the policies and its potential effect and ways to keep the participants well by developing coping mechanisms to handle the stress generated by talking about these sensitive topics.

Psychoeducational Workshops: We offered a caregiver's workshop on the sign of depression to Family Bridges caregivers (Vietnamese, Cantonese, Mandarin groups). Each workshop had up to six participants to attend. Two major lessons gained from the workshops are recognizing the urgent needs for attention and support in especially senior caregiver community and strengthening the foundation of our programs and services to the Chinese community. The workshops incorporated cultural sensitivity into the western idea of mental health concept for seniors to understand and further relate to their own experience. From engaging senior caregivers with activities designed to remind their identity as an individual before they took on the caregiver role to creating a warm and secure space where they found comfort and resonation, these seniors undoubtedly broke the stereotype and shared their vulnerability in public.

We also provided a workshop discussing the intersection of academic stress and parenting communication skills. We partnered with IWAY (Improving the Wellness of Asian Youth) and presented the topic of academic stress to English, Spanish, and Chinese speaking community at Oakland Charter High School. The workshop provided signs of getting stressed and burnout as well as methods to navigate the struggle with internal and external support. This workshop generated an opportunity where parents and students shared their perspectives face to face, learned to recognize systemic and cultural impact on academic achievement and its potential risk, empathized struggles from both sides, and brainstormed ideas to support themselves as well as each other.

Education Workshops: We co-hosted a technology workshop for seniors with the Korean American Community Foundation. This workshop provided technology assistance for seniors in Korean language through a mental health framework. We discussed issues of isolation and loneliness and the role that technology can play to support connection and then learned how to use the mobile phone. We had 20 participants and they were eager to learn a practical topic. While new community members did not understand the mental health framework, our longstanding Jikimee leaders were able to discuss the importance of mental health for communities. We also provide a "Compassion Fatigue & Self Care" educational workshop to our collaborative partner Helping Hand of the East Bay (HHEB) to providers working with family members with developmental disability. Through this workshop, we educated providers on mental health signs and symptoms of compassion fatigue and burn out, including developing strategies to reduce burn out risks and promote self- care and setting healthy boundaries in the work environment in order to better support the providers themselves and their clients long term.

Community Events: KCCEB's community events included: Halmoni Movie Screening, KCCEB Open House, World Refugee Day, and Legal Clinic. The **Halmoni Movie Screening** was an opportunity for Korean seniors and Korean American community members to learn about the impact of immigration on intergenerational family dynamics. Seniors and members were able to hear a personal immigration story and learn about the current immigration system and how it impacts the health and well-being of families. During the **Open House**, Korean and Chinese community members learned about mental health symptoms and feelings through cultural food metaphors. This innovative method allowed people to connect to mental health in a physical way as they could try the food from their culture and connect with how the food feels and how that is related to mood. Community members also had an opportunity to make mental health bookmarks. KCCEB was one of the planning committee members of **World Refugee Day**.

We made an immigration timeline for community members to learn about how their arrival coincided with historic US events. We also tabled and shared information on our services. We collaborated with International Rescue Committee (IRC) and East Bay Sanctuary Convent to host a **Legal Clinic event** to support API community members to apply for naturalization and promote mental health awareness to the community. We had an opportunity to discuss with immigrant and refugee community members current political stressors that impact their wellness. In additional, we shared with community members about available mental health services to support individuals and family members struggling with multiple stressors and traumas due to the current political climate.

Materials distributed: This year, we developed new materials including a program flyer, MH topic flyers (stress, anxiety, anger management, depression, sexual consent, and loneliness, etc.), and community events posters. All flyers were available in English, Korean and Chinese. They were distributed at churches, schools, local community and senior center outreach events, senior housing visits, support groups, World Refugee Day, Legal clinic events, KCCEB newsletters, and Facebook. While noticing an increased number of community members searched resources online, we utilized Facebook to disseminate resources, opportunities, and education information to the community. Our goal is to create a resource hub for people to gain access to resources not only within our organization but also from other local organizations in Alameda County.

Prevention Visits (34 Clients): Our clients are predominantly East Asian youths. We have developed a referral partnership with IWAY, Alameda Science and Technology Institute, San Leandro High School, and Peralta Community College School District. Our youth clients face challenges with family relationships, historical and intergenerational traumas, depression, anxiety, anger management, school and relational conflicts. We also provided counseling support to monolingual Chinese and Korean speaking adults struggling with depression, grief and loss, marital conflicts, and family stressors. These individuals came from referrals from legal services, community based and faith based organizations, senior housing facilities, and through our community outreach events throughout Alameda County.

2. What were the challenges and how did your agency mitigate challenges?

Case Management Needs: Many of our East Asian adults and older adults clients struggle with an array of stressors as they walked through KCCEB door, leading them to have symptoms of anxiety or depression.
As monolingual speaking Chinese or Korean clients, they often feel a lack of trust with the system and neglected by the public. It is challenging to reach out and build trust with the community when we have a limited number of staff and funding. Staff has to weight between quality and quantity, and sometimes in order to meet the deliverables they might not be able to provide a more comprehensive care, namely housing, social services, physical assistance, and emotional support, for each client.

Mental Health Preventative Counseling Needs: The biggest challenge we learned from community members and local schools is that the support for MH needs targeting at API community is insufficient. API community constitutes approximately 30% of the population in Alameda County. Yet API youth often encountered biased judgment or mistreatment due to their model minority while reaching out to seek MH support. It is difficult for them to relate to school staff or MH providers when they lack cultural competency. We look forward to the County initiating more conversations in the system and at schools to raise awareness regarding stereotypes, labels, and each unique individual challenges API youth are facing.

Undocumented youth work: It has been a challenge to outreach to the undocumented community living in the East Bay mostly because of the current political landscape that has undone a lot of progress that undocumented communities have achieved.

There's not an adequate way to assess the needs of the undocumented youth needs in Alameda County because this is a population that is often challenging to reach out to due to its diversity such as cultural differences and language spoken. In addition, the lack of visibility of undocumented issues and the stigma within their own communities are often the larger obstacles to outreach to undocumented API youth. It's a necessary more long-term investment in the efforts and strategies to continue outreaching in these communities.

Community Need: The major structural challenge with the UELP program is that the staffing is limited and the community need is great. This results in frustration from staff and stretching staff in different directions. For example, our Korean language staff focuses her work on seniors including the support group, doing community outreach providing one-on-one resource and referrals and supporting volunteers for our senior program. With only a half time position it would be very hard to also add other age groups (youth, families, parents, etc). We have seen that struggle with our Chinese language staff who also has a MFT. This staff member sees mental health clients in schools, as well as families, adults and seniors. They conduct trainings and outreach with youth, parents and caregivers of seniors. It is hard to say "no" when the community need is great. This structural challenge due to set funding guidelines creates an environment where burnout is very likely. Thus, to better support the diverse Asian communities, a more robust funding is needed for capacity building.

3. Please describe the innovative ways your program has weaved the topics of mental health/emotional well-being into your activities. Please give at least one example.

Technology workshop: KCCEB staff often hear Korean senior clients inquire about the inconvenience of using technology device. According to them, these new devices affect their life including communication with others, self-education and opportunity for the future. We also had a number of jikimee support group members who expressed their emotional stress from struggles of lack of technology skills and intergenerational conflicts. We decided to host a technology workshop for a 3 hour event in KCCEB to allow Korean seniors to share their barriers and ambition to learn modern technology skills. The main activity was to bring together the relationship between technology use and our life with family and friends. This was a collaboration between Korean American Community Foundation, Asian Health Services, KCCEB and six volunteers. Asian Health Services offered a presentation linking mental health with healthy way of using devices.
Overall, the participants gained skills and practiced using device applications and understanding a mental health framework with technology usage. Following the workshop, we received several requests to repeat the similar workshop.

In partnership with ASPIRE, the first pan-Asian undocumented youth group in the country. We hosted the Halmoni Screening which was an event to allow Korean seniors to understand immigration through the lens of an undocumented person. It consisted of the 20 participants to explore their own immigration history in the context of what was happening in their home countries and what current U.S. policies either allowed or prevent them to immigrate here. This created a unique perspective that their stories were part of something much bigger than themselves. It also provided an open forum to discuss mental health consequences of immigration. The main activity was the screening of the short-documentary Halmoni, which translates to a grandmother in Korean. It follows a story of an ASPIRE member, an undocumented Korean young adult living in Alameda. As a DACA recipient, the protagonist is allowed to temporarily travel to Korean to visit his aging grandmother. The story focuses on family and love in the context of immigration being a barrier to achieving them. In this event, the audience was able to learn common myths about undocumented immigrants and debunking these stereotypes with facts and opening up conversation about the mental health impacts of immigration that are rarely discussed in a public setting. Overall, the audience appreciated the learning opportunity to expand their mind and hearts.

Food and MH tasting: While we struggled about how to present MH concept to the general public about in a very short time, the idea of incorporating what people feel the closest to, namely food, into the message came out. Recognizing both Korean and Chinese communities share similar food item, we used various styles of rice cake into five different emotions. From the taste, smell, and the look of the rice cake to the similarities each emotion brings to us physically, mentally, and emotionally, members read through the description and learned to recognize their feelings and further provoked their interest in self-reflection and generating awareness.

4. Please describe how your program has encouraged access to your services and your strategies for successful linkage for mental health treatment.

For the past year, ACWP provided multiple mental health workshops, educational trainings and wellness outreach throughout Alameda County. Through these activities, we actively shared the importance of seeking mental health services prior to the individual symptoms worsening to individual community members, leaders, and providers in faith based, school based, and community based organizations. We also provide individual consultation to family members, community leaders, faith leaders at churches, providers at community based organization and school based programs partners, to help screen and detect signs and symptoms of mental health problems. Through our outreach and education strategies efforts, and with trusted collaboration and partnerships with school based, faith based, and community organizations, community members were referred to ACWP preventive counseling services where our Mental Health Specialist and Wellness Coordinator provided mental health screening, assessment, case management and counseling services to engage clients to help address and manage their mental health symptoms. While receiving preventive counseling services, staff monitor the clients' mental health symptoms, help clients develop coping skills to manage their symptoms, provided psycho-education to better understand their symptoms and reduce mental health stigma, thus being able to successfully referred clients to treatment program when necessary due to the trust and rapport building between staff and client. Thus far, we had one client in need to mental health treatment services that we were able to successfully referred. The Mental Health Specialist assisted the client to contact the ACCESS line for mental health intake, help the client schedule the initial visit for mental health intake and psychological evaluation, and ensure that the client attended the initial psychiatric session for the psychotropic medication evaluation. As a result, this client was able to receive services to address his depressive symptoms with psychotic features.

5. Describe how your program interacted with various other ACBH funded programs such as school-based programs, other prevention programs, the stigma and discrimination reduction campaign, 10 x 10 campaign etc.

This year, KCCEB partnered with other UELP providers in three ways. First, we met with other partners (AHS, CERI, FAJ, Tri-City) to support our on-boarding and trouble-shooting as new providers. It was helpful to learn how other providers have been doing the work and also share lessons learned. Second, we partnered with CERI and Asian Refugees United to develop a grant proposal to serve Asian youth for mental health using the arts for a City of Oakland OFCY grant. While we were not awarded for that grand, we did receive some funding from the City of Oakland do this work. Third we partnered with CERI, DHTI, Asian Refugees United, BRFN and Refugee Transitions to do Census Outreach this coming year. We believe working together we can address similar challenges our communities face and also increase the visibility of immigrants and refugees in Alameda County.

In partnership with IWAY, we created a referral system that IWAY will refer students from their summer programs or internship to our preventative counseling services as needed and work to engage youth in reducing stigma in order to seek mental health services in the community and schools. IWAY started outreaching to community since 2017 and has been connecting with local schools to recruit API youth for leadership building ever since.

Through our partnership with IWAY, we were able to support IWAY to expand services to API youth and be able to provide MH education to promote MH awareness, MH resources, and provide preventative counseling to API youth to reduce the risk of them falling through the cracks in the school system. Through the collaboration with Alameda Science and Technology Institute, San Leandro HS, and Peralta Community College District, we were invited to their MH committee meetings, COST meetings, and MH school events. We addressed MH concerns API youth are facing, provided consultation to staff members on how to support API students considering the nature of repressing their feelings and hiding their struggles from the school and parents as well as helped them create a safety net where API youth can reach out or be referred to in response to the needs.

6. What are your goals for your program for the upcoming fiscal year?

   This year we will continue to provide

- Combining outreach and counseling roles for each outreach worker to promote mental health awareness and increase capacity to provide preventive counseling services for the diverse East Asian communities.

- **School-based work (continue to build and strengthen our collaborative partnership with school based programs)**
  - IWAY
  - Alameda Science and Technology Institute
  - San Leandro HS
  - Peralta Community College District

- **Wellness and Leadership Support Group**
  - Koreans (Jikimee leadership) to support elder to promote mental health awareness in the community, engage community members to seek mental health services, and advocate for culturally responsive MH services for Korean and other API communities.
  - Growing with Chinese South County - expanding services to Chinese community in Central and South County.
  - Korean Elder Support Group (to reduce social isolation, strengthen their knowledge in access essential community resources, develop coping skills to manage acute stress, depression, and anxiety symptoms, and strengthen inter-generational relationships).
  - Taichi support group for East Asian adult and elders to improve their physical and mental health wellbeing. To help address anxiety and fear of falling and support each other in the community.

ACCESS & LINKAGE TO MENTAL HEALTH TREATMENT (QUESTION 1 AND 3 ARE REQUIRED PER YOUR EXHIBIT A - QUALITY MEASURES)

1. Number of individuals with serious mental illness (SMI) or exhibit symptoms of a SMI who received a paper referral (i.e. referrals via phone do not apply) from your program…
   a. To an ACBH-funded mental health treatment program: 1
   b. To a non-ACBH-funded mental health treatment program: n/a

   Because we are a newly BCHS sub-contracted organization, we are currently providing preventive counseling to our clients. Of the 34 clients, only one needed MH treatment referral.

We were able to successfully support the client to access mental health treatment services (i.e. securing appointment for initial assessment, completing visit with therapist, psychotropic medication evaluation with psychiatrist) prior to discharging him from our preventive counseling program. The remaining 33 clients are still in our preventive counseling program.

2. List type(s) of mental health treatment programs the individual was referred to (i.e. outpatient, inpatient, etc.): 1 client was successfully referred to an outpatient MH treatment program

3. Number of individuals who were successfully referred and linked (i.e. client has been seen at least once in person by a treatment provider):
   a. To an ACBH mental health treatment program:1
   b. To a non-ACBH-funded mental health treatment program: n/a

4. Average duration in weeks of signs of untreated mental illness (per client self-report) *(write "n/a" or "unknown" when applicable): 2 weeks to 2 months on average*

5. Average time in weeks between when a paper referral was given to individual by your program and the individual's first in person appointment with a mental health treatment provider *(write "n/a" or "unknown" when applicable)*: 2 weeks

Timely Access (to other PEI-funded programs)

1. Number of separate paper referrals to another ACBH **PEI-funded** program. *(write "n/a" or "unknown" when applicable)*: n/a

2. Number of individuals followed through on referral & engaged in an ACBH PEI-funded program *(write "n/a" or "unknown" when applicable)*: 1 for MH treatment program, 33 for PEI preventive counseling, 12 for Wellness leadership and support group.

3. Average time in weeks between when a paper referral was given to individual by your program and the individual's first in person appointment with the ACBH PEI-funded provider *(write "n/a" or "unknown" when applicable)*: 2 weeks to one month due to client's cancellation.

UELP Prevention Data Report FY 18/19

MHSA Program Number: PEI 6
Program Name: Outreach, Education & Consultation for Asian Pacific Islander Community- RAMS Pacific Islander Wellness Initiative

RAMS Pacific Islander Wellness Initiative provides culturally responsive prevention and early intervention mental health services to Alameda County's Pacific Islanders, including Native Hawaiians. RAMS, in collaboration with long-standing and trusted Pacific Islander community-based organizations, Taulama, Samoan Community Development Center, and Regional Pacific Islander Taskforce implements an array of culturally and linguistically responsive outreach/engagement and psycho-education services, mental health consultation, preventive counseling, and mental health referrals. Our priority populations are all ethnicities and communities, with a special focus on **Pacific Islanders, including Native Hawaiians** in the Northern and Southern regions of Alameda County.

General Information & Total Numbers Served

Total Numbers Served through PEI MHSA		
Number of unduplicated individuals your program serves who are **at-risk** of developing a mental health problem or serious mental illness (SMI)	**A**	273
Number of unduplicated individuals your program serves who show **early signs** of forming a more severe mental illness	**B**	8
Number of unduplicated individual family members served indirectly by your program:	**C**	
Grand TOTAL of unduplicated individuals served in the Quarter that you are reporting about. [This number (D) should = A+B+C.]	**D**	281

DEMOGRAPHICS

Age Group (Unduplicated)	
Children/Youth (0-15)	21
Transition Age Youth (16-25)	70
Adult (26-59)	164
Older Adult (60+)	18
Unknown/ Declined to Answer	

Race (Please mark only one choice) *If Hispanic or Latino, choose "Another race not listed."*	
American Indian or Alaska Native	
Asian	160
Black or African American	
Native Hawaiian or other Pacific Islander	109
White	4
More than one race	
Another race not listed	
Unknown/ Declined to Answer	

Sexual Orientation (Please mark only one choice)	
Gay or Lesbian	18
Heterosexual or Straight	215
Bisexual	
Questioning or unsure of sexual orientation	
Queer	
Another sexual orientation not listed	
Unknown/Decline to Answer	40

Ethnicity /Cultural Heritage (Please mark only once choice)	
If Hispanic or Latino, please specify:	
Caribbean	
Central American	
Mexican/Mexican--American/Chicano	
Puerto Rican	
South American	
Another Hispanic/Latino ethnicity not listed	
Unknown/Declined to Answer	
If Non-Hispanic or Non-Latino, please specify:	
African	
African American	
Asian Indian/South Asian	
Cambodian	1
Chinese	2
Eastern European	
European	
Filipino	6
Japanese	
Korean	
Middle Eastern	
Vietnamese	
Other Non-Hispanic or Non-Latino ethnicity not listed Fijian – 7 Native Hawaiian – 1 Samoan - 93 Tongan – 150 Other Pacific Islander - 8	259
More than one ethnicity	
Unknown /Declined to Answer	

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

Primary Language (Please mark only one choice)	
English	
Spanish	
Farsi	
Cantonese	
Mandarin	2
Other Chinese Dialects	
Vietnamese	1
Korean	
Tagalog	6
Other Filipino Dialect	
Japanese	
Laotian	
Cambodian	1
Mien	
Hmong	
Samoan	
Thai	
Russian	
Polish	
German	
Italian	
Turkish	
Hebrew	
French	
Portuguese	
Armenian	
Arabic	
Sign ASL	
Other primary language not listed Fijian – 7 Hawaiian – 1 Tongan- 150 Other - 12	170
Unknown/ Decline to Answer	

Gender Identity (Please mark both parts A & B)	
A) Assigned sex at birth: (Please mark only one choice)	
Male	110
Female	163
Other sex not listed (e.g. Intersex)	
Unknown/Decline to Answer	
B) Current Gender Identity: (Please mark only one choice)	
Male	
Female	
Transgender	
Genderqueer	
Questioning or Unsure of Gender Identity	
Another Gender Identity not listed	
Unknown/Decline to Answer	273

Disability Status (Please mark all that apply)	
None	216
Yes. If yes, please specify (choose from list below):	
Difficulty Seeing	4
Difficulty hearing, or having speech understood	
Mental Domain	
Physical/Mobility Domain	3
Chronic Health Condition	1
Another disability not listed	
Unknown/Decline to Answer	49

Veteran Status (Please mark only one choice)	
Yes	16
No	193
Unknown/Decline to Answer	64

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

Program Overview

1. What were the successes/accomplishments of the past year? Please provide one example or case study of success your agency is most particularly proud.
   PIWI accomplished the following:
   - Established a mental health, prevention and early intervention activities and services for Pacific Islanders in Alameda County
   - On-boarding of the Mental Health Specialist who also identifies as a PI, albeit temporarily, while we continue to search for a permanent candidate; this enabled us to visualize the true potential of this type of program for underserved, hard to reach populations
   - Within one month of on-boarding the Mental Health Specialist, 6 clients were referred by community partners for preventive counseling
   - Hiring of health navigators who are bicultural and bilingual

2. What were the challenges, and how did your agency mitigate challenges?
   PIWI program experienced several challenges in the first six months of implementation:
   - Recruitment of the Mental Health Specialist – this position is filled temporarily by a Pacific Islander (Psy.D) candidate until August and had started in the first week of June. We had identified and interviewed another Pacific Islander (master's level psychology) individual who will be starting in August, and his availability is limited to 6-8 hours per week. We are continuing to screen and interview candidates to support this position at full capacity.
   - Staff turnover with RAMS and community partners. Two staff left their positions in April. One due to health matters and the other due to schedule conflicts. RAMS has hired a replacement for the program/data clerk position and due to start mid-July.
   - Acclimating and learning Alameda County Health Systems and Behavioral Health Systems landscape and systems – Staff attended training on InSyst, Clinician Gateway, and MAA Billing. We are gradually learning the flow of our work and using these data systems. We are attending grantee meetings and other ancillary meetings to learn and explore more about county systems and also existing resources and services in the county, as well as professional development opportunities. We are learning about Administrative nuances and so forth.
   - Identifying and learning about the county of Alameda – we are learning about Alameda County; about existing resources and services to support individuals in their healing and recovery. We are learning more about Pacific Islanders that live here.

3. Please describe the innovative ways your program has weaved the topics of mental health/emotional well-being into your activities. Please give at least one example.

   PIWI used the "talanoa" method to facilitate group dialogue around mental health and wellness/emotional well-being. The group is called Talanoa4Wellness. PIWI conducted one-cycle of four weeks (weekly), averaging 8 – 10 participants per group. Talanoa is based on the Pacific concept of "talanoa," which is dialogue between two or more people formally or informally. The process is designed to allow for participants to share their stories in an open, safe, and inclusive setting to open up about mental health and mental illness; and thus, creating an opportunity to breakdown stigma. The shared space lets people share their vulnerability and also showcased resiliency in overcoming or coping with mental health and stigma associated with mental illness they face as individuals and members of family and community. The group was facilitated by an experience bilingual and bicultural facilitator. The majority of adult participants had never shared their stories or experience about mental health and mental illness before; and would have never did without Talanoa4Wellness.
   Another activity PIWI conducted was *Hot Siva* (dance), which is a physical activity that uses Samoan/Pacific Islander movements combined with Samoan/Pacific/contemporary beats/music for a low-moderate intensity exercise routine.

4. Please describe how your program has encouraged access to your services and your strategies for successful linkage for mental health treatment.
   Most of the PIWI staff are Alameda County residents who have wide networks of contacts via church membership, familial relations, schools and college affiliates, community members and providers from other sectors, for which to tap into to reach the community. Staff and partners are actively promoting the program via social media postings, newsletters, etc., as well as attending various community events directed to the Pacific Islander community. In addition, PIWI staff followed up with members who attended the community events via phone call and email and personally offered services.

5. Describe how your program interacted with various other ACBH funded programs/projects such as school-based programs, other prevention programs, the stigma, and discrimination reduction campaign, 10 x 10 campaign, etc.
   RAMS is new to Alameda County, and we are learning about and familiarizing with the various other ACBH funded programs/projects. PIWI staff made contacts with Logan High School and Hayward High School. PIWI staff has also regularly attended grantee meetings to learn and know more about the diverse communities and their activities to promote mental health. PIWI developed a working relationship with the Bay Area Community Services (BACS) in Hayward to utilize their space for community convening. PIWI partners have also been in communication with the Alameda Health Consortium to participate in their monthly peer network conversations around behavioral/mental health and facilitating the opportunity to partner with those community health centers serving the priority population within the mental health work.

6. What are your goals for your program for the upcoming fiscal year?
   PIWI's goals for the next fiscal year are: hiring of mental health specialist and filling all positions required, outreach and engage more Pacific Islanders, particularly Melanesians and Micronesians, with faith-based of all denominations, student groups on college campus, providers, among others; provide training and mentoring to health navigators (aka outreach workers); and continuing to build upon partnerships with other Alameda County groups.

ACCESS & LINKAGE TO MENTAL HEALTH TREATMENT (QUESTION 1 AND 3 ARE REQUIRED PER YOUR EXHIBIT A - QUALITY MEASURES)

1. Number of individuals with serious mental illness (SMI) or exhibit symptoms of an SMI who received a paper referral (i.e., referrals via phone do not apply) from your program…
   a. To an ACBH-funded mental health treatment program: 0
   b. To a non-ACBH-funded mental health treatment program: 0

2. List type(s) of mental health treatment programs the individual was referred to (i.e., outpatient, inpatient, etc.):
   PIWI community partner (TOLU) referred clients needing mental health support to RAMS mental health specialist. No clients were referred to treatment programs. It is anticipated that there would be #s in the next fiscal year as more community members and providers know about the program and the services/activities offered.

3. Several individuals who were successfully involved and linked (i.e., the client has been seen at least once in person by a treatment provider):
   a. To an ACBH mental health treatment program: 0
   b. To a non-ACBH-funded mental health treatment program: 0

4. The average duration in weeks of signs of untreated mental illness (per client self-report) *(write "n/a" or "unknown" when applicable): n/a*

5. Average time in weeks between when a paper referral was given to an individual by your program and the individual's first in-person appointment with a mental health treatment provider *(write "n/a" or "unknown" when applicable)*: n/a

TIMELY ACCESS (TO OTHER PEI-FUNDED PROGRAMS)

1. Several separate paper referrals to another ACBH PEI-funded program. *(write "n/a" or "unknown" when applicable)*: n/a
2. A number of individuals followed through on referral & engaged in an ACBH PEI-funded program *(write "n/a" or "unknown" when applicable)*: 8
3. Average time in weeks between when a paper referral was given to an individual by your program and the individual's first in-person appointment with the ACBH PEI-funded provider*(write "n/a" or "unknown" when applicable)*: n/a

UELP Prevention Data Report FY 18/19

MHSA Program Number: PEI 6
Program Name: Outreach, Education & Consultation for Asian Pacific Islander Community-Tri-City Health Center Arise Asian Wellness Project

Arise: Asian Wellness Project. Target population is East Asians (Chinese, Korean, Japanese, Taiwanese) in South Alameda County.

General Information & Total Numbers Served

Total Numbers Served through PEI MHSA		
Number of unduplicated individuals your program serves who are **at-risk** of developing a mental health problem or serious mental illness (SMI)	A	1,134
Number of unduplicated individuals your program serves who show **early signs** of forming a more severe mental illness	B	32
Number of unduplicated individual family members served indirectly by your program:	C	
Grand TOTAL of unduplicated individuals served in the Quarter that you are reporting about. [This number (D) should = A+B+C.]	D	1,166

Demographics

Race (Please mark only one choice) *If Hispanic or Latino, choose "Another race not listed."*	
American Indian or Alaska Native	
Asian	
Black or African American	
Native Hawaiian or other Pacific Islander	
White	
More than one race	
Another race not listed	
Unknown/ Declined to Answer	

Age Group (Unduplicated)	
Children/Youth (0-15)	60
Transition Age Youth (16-25)	195
Adult (26-59)	1,019
Older Adult (60+)	161
Unknown/ Declined to Answer	

Primary Language (Please mark only one choice)	
English	798
Spanish	
Farsi	
Cantonese	
Mandarin	431
Other Chinese Dialects	
Vietnamese	
Korean	
Tagalog	
Other Filipino Dialect	
Japanese	
Laotian	
Cambodian	
Mien	
Hmong	
Samoan	
Thai	
Russian	
Polish	
German	
Italian	
Turkish	
Hebrew	
French	
Portuguese	
Armenian	
Arabic	
Sign ASL	
Other primary language not listed Other - 207	207
Unknown/ Decline to Answer	

Ethnicity /Cultural Heritage (Please mark only once choice)	
If Hispanic or Latino, please specify:	
Caribbean	
Central American	
Mexican/Mexican--American/Chicano	
Puerto Rican	
South American	
Another Hispanic/Latino ethnicity not listed	
Unknown/Declined to Answer	
If Non-Hispanic or Non-Latino, please specify:	
African	
African American	
Asian Indian/South Asian	
Cambodian	
Chinese	661
Eastern European	
European	
Filipino	
Japanese	
Korean	3
Middle Eastern	
Vietnamese	
Other Non-Hispanic or Non-Latino ethnicity not listed Other Asian- 469	469
More than one ethnicity	
Unknown /Declined to Answer	

Sexual Orientation (Please mark only one choice)	
Gay or Lesbian	
Heterosexual or Straight	2
Bisexual	
Questioning or unsure of sexual orientation	
Queer	
Another sexual orientation not listed	
Unknown/Decline to Answer	1,433

Veteran Status (Please mark only one choice)	
Yes	1
No	64
Unknown/Decline to Answer	1,435

Disability Status (Please mark all that apply)	
None	3
Yes. If yes, please specify (choose from list below):	
Difficulty Seeing	
Difficulty hearing, or having speech understood	
Mental Domain	
Physical/Mobility Domain	
Chronic Health Condition	
Another disability not listed	
Unknown/Decline to Answer	1,432

Gender Identity (Please mark both parts A & B)	
A) Assigned sex at birth: (Please mark only one choice)	
Male	585
Female	850
Other sex not listed (e.g. Intersex)	
Unknown/Decline to Answer	
B) Current Gender Identity: (Please mark only one choice)	
Male	
Female	
Transgender	
Genderqueer	
Questioning or Unsure of Gender Identity	
Another Gender Identity not listed	
Unknown/Decline to Answer	1,435

Program Overview

1. What were the successes/accomplishments of the past year? Please provide one example or case study of a success your agency is particularly proud of.

   One of our successes was being able to reach underserved seniors with no services or way of communicating with staff at their apt complex. We are also proud of being able to set up partnerships with local high schools and senior housing complexes and providing services to their students and residents respectively.
   We reached out to a senior apt complex called Avelina in Fremont. Each time we have been there, we've noticed that it's made a significant impact on the mood of the seniors. They were very enthusiastic and seem uplifted after each support group or workshop. They seemed very appreciative of our services and the fact that we were able to communicate with them in their own language. They seem to look forward to every group. The staff were also very happy to have us and appreciated that we could help them communicate with the residents.

2. What were the challenges and how did your agency mitigate challenges?

   One of the challenges was staffing. We weren't able to get a Mental Health Specialist onboard until April 2019. This delayed the preventative counseling and prevention visits services. We kept a wait-list of patients who would be ready to be scheduled and seen once the MHS came onboard.
   Another challenge was getting interest from the community to attend groups or events, due to stigma and being a new program. Once we collaborated with the schools, we had support of their staff to help promote our services and make referrals to us for the support groups and preventative counseling.

3. Please describe the innovative ways your program has weaved the topics of mental health/emotional well-being into your activities. Please give at least one example.

   During a youth support group, we had the participants create their own self-care kits and provided education on importance of self-care. All participants were engaged and gave feedback that they enjoyed the activity. It was also a good reminder for them to practice self-care outside of the group.

4. Please describe how your program has encouraged access to your services and your strategies for successful linkage for mental health treatment.

   We had partnerships with some of the local high schools and made prevention visits to the school when there was a referral. Our goal of going out to meet them in the community was to reduce access to care for the students. We've also tried to encourage referred individuals to meet w/ the MHS by informing them we could meet them where they felt comfortable. Our partnerships and collaborative effort with school staff, community leaders, and Primary Care Providers have assisted with encouraging participants to be linked to mental health treatment.

5. Describe how your program interacted with various other ACBH funded programs/projects such as school-based programs, other prevention programs, the stigma and discrimination reduction campaign, 10 x 10 campaign etc.

   We have invited Hume Center's UELP program to a tabling event at a high school that has majority Asian and South Asian students, so students and parents could learn about both of our services. I have also been in contact with Korean Community Center of the East Bay staff to help find resources for participants since we serve the same ethnic populations but in different parts of the county. Our UELP programs also invite each other to our respective programs' events to provide support.

6. What are your goals for your program for the upcoming fiscal year?

   Our goals are to expand the type of workshops. We hope to include yoga classes as another method to help participants increase their protective factors. We also hope to utilize volunteers and contracted speakers to provide different topic workshops. Another goal is to expand services to college aged students by creating a partnership with colleges. We have already started the conversation with a local community college.

ACCESS & LINKAGE TO MENTAL HEALTH TREATMENT (QUESTION 1 AND 3 ARE REQUIRED PER YOUR EXHIBIT A - QUALITY MEASURES)

1. Number of individuals with serious mental illness (SMI) or exhibit symptoms of a SMI who received a paper referral (i.e. referrals via phone do not apply) from your program…
   a. To an ACBH-funded mental health treatment program: 2, all other referrals were via phone
   b. To a non-ACBH-funded mental health treatment program: 0

2. List type(s) of mental health treatment programs the individual was referred to (i.e. outpatient, inpatient, etc.): Outpatient mental health treatment, inpatient psychiatric hospital, outpatient psychiatric services

3. Number of individuals who were successfully referred and linked (i.e. client has been seen at least once in person by a treatment provider):
   a. To an ACBH mental health treatment program: 6
   b. To a non-ACBH-funded mental health treatment program: 0

4. Average duration in weeks of signs of untreated mental illness (per client self-report) *(write "n/a" or "unknown" when applicable): unknown*

5. Average time in weeks between when a paper referral was given to individual by your program and the individual's first in person appointment with a mental health treatment provider *(write "n/a" or "unknown" when applicable)*: unknown

TIMELY ACCESS (TO OTHER PEI-FUNDED PROGRAMS)

1. Number of separate paper referrals to another ACBH **PEI-funded** program. *(write "n/a" or "unknown" when applicable)*: 0, all referrals via phone

2. Number of individuals followed through on referral & engaged in an ACBH PEI-funded program *(write "n/a" or "unknown" when applicable)*: 0

3. Average time in weeks between when a paper referral was given to individual by your program and the individual's first in person appointment with the ACBH PEI-funded provider*(write "n/a" or "unknown" when applicable)*: n/a

UELP Prevention Data Report FY 18/19

MHSA Program Number: PEI 7
Program Name: Outreach, Education & Consultation for South Asian/Afghan Community-Afghan Wellness Center

Afghan Wellness Center is a project of The Afghan Coalition, a non-profit, community based organization located in Fremont. We consist of a bilingual/bicultural staff that supports the underserved Afghan community. The AWC works with individuals that are isolated or trauma-exposed, immigrants, families under stress or grieving, at risk children and youth as well as any individual at risk of early onset of a serious mental health issue by providing prevention and early intervention services in Dari, Pashto and English. AWC provides advocacy and screening, educational workshops, support groups, outreach and resources and referrals to families and refugees.

General Information & Total Numbers Served

Total Numbers Served through PEI MHSA		
Number of unduplicated individuals your program serves who are **at-risk** of developing a mental health problem or serious mental illness (SMI)	**A**	3,010
Number of unduplicated individuals your program serves who show **early signs** of forming a more severe mental illness	**B**	46
Number of unduplicated individual family members served indirectly by your program:	**C**	
Grand TOTAL of unduplicated individuals served in the Quarter that you are reporting about. [This number (D) should = A+B+C.]	**D**	3,056

DEMOGRAPHICS

Age Group (Unduplicated)	
Children/Youth (0-15)	228
Transition Age Youth (16-25)	556
Adult (26-59)	1,414
Older Adult (60+)	812
Unknown/ Declined to Answer	

Race (Please mark only one choice) *If Hispanic or Latino, choose "Another race not listed."*	
American Indian or Alaska Native	
Asian	2,704
Black or African American	40
Native Hawaiian or other Pacific Islander	
White	114
More than one race	
Another race not listed	119
Unknown/ Declined to Answer	33

Sexual Orientation (Please mark only one choice)	
Gay or Lesbian	
Heterosexual or Straight	53
Bisexual	28
Questioning or unsure of sexual orientation	
Queer	
Another sexual orientation not listed	2,929
Unknown/Decline to Answer	

Ethnicity /Cultural Heritage (Please mark only once choice)	
If Hispanic or Latino, please specify:	
Caribbean	
Central American	
Mexican/Mexican--American/Chicano	
Puerto Rican	
South American	
Another Hispanic/Latino ethnicity not listed	
Unknown/Declined to Answer	
If Non-Hispanic or Non-Latino, please specify:	
African	
African American	
Asian Indian/South Asian	
Cambodian	
Chinese	
Eastern European	
European	
Filipino	
Japanese	
Korean	
Middle Eastern	
Vietnamese	
Other Non-Hispanic or Non-Latino ethnicity not listed-AFGHAN	2,704
More than one ethnicity	
Unknown /Declined to Answer	

Primary Language (Please mark only one choice)	
English	302
Spanish	
Farsi	389
Cantonese	
Mandarin	
Other Chinese Dialects	
Vietnamese	
Korean	
Tagalog	
Other Filipino Dialect	
Japanese	
Laotian	
Cambodian	
Mien	
Hmong	
Samoan	
Thai	
Russian	
Polish	
German	
Italian	
Turkish	
Hebrew	
French	
Portuguese	
Armenian	
Arabic	
Sign ASL	
Other primary language not listed Dari - 1684 Pashto - 362	2,046
Unknown/ Decline to Answer	

Gender Identity (Please mark both parts A &	
A) Assigned sex at birth: (Please mark only one choice)	
Male	1,356
Female	1,654
Other sex not listed (e.g. Intersex)	
Unknown/Decline to Answer	
B) Current Gender Identity: (Please mark only one choice)	
Male	
Female	
Transgender	
Genderqueer	
Questioning or Unsure of Gender Identity	
Another Gender Identity not listed	
Unknown/Decline to Answer	

Disability Status (Please mark all that apply)	
None	34
Yes. If yes, please specify (choose from list below):	
Difficulty Seeing	
Difficulty hearing, or having speech understood	
Mental Domain	3
Physical/Mobility Domain	1
Chronic Health Condition	1
Another disability not listed	
Unknown/Decline to Answer	2,971

Veteran Status (Please mark only one choice)	
Yes	
No	73
Unknown/Decline to Answer	2,937

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

PROGRAM OVERVIEW

1. What were the successes/accomplishments of the past year? Please provide one example or case study of a success your agency is particularly proud of.

Some of our successes were implementing a weekly afterschool program to support youth, several cultural events bringing the community together and reducing isolation, reaching isolated clients through home visits and establishing seven monthly support groups. We were honored when our Executive Director, Rona Popal, and our Associates Dr. Valerie Smith, Dr. Nilofar Sami and Mizgon Darby, were named the recipients of the 2019 Ulysses Medal for Leadership in Refugee Health from the UC Davis School of Medicine.

One case we are particularly proud of is when we were able to help an extremely depressed client. Our client, with a pending Asylum case, married a recently divorced man who later left to reunite with his ex-wife. We were able to provide her with culturally sensitive emotional support, a home visit, linked her to our mental health prevention counseling and encouraged her to attend other mental health wellness events. The client attended a Spiritual Healing presentation by Dr. Masoud Ghafoer. She later said, "It was like a spark which changed me overnight. After that, I definitely know how to take care of myself." The client continues to come to the office with renewed hope about her future. Another case involved an Afghan man who had severe symptoms of PTSD and we were able to help him learn how to regulate his emotions, help him reduce his symptoms and connect him with a psychologist who helped him with more in-depth trauma work.

2. What were the challenges and how did your agency mitigate challenges?

One challenge we faced was starting our youth program. We began with the expectation that families would come to our office for events but quickly learned that it was difficult for the parents to transport their children. To mitigate this we hosted a Parent Workshop as a listening forum and discovered that the best way to reach the youth would be to host events at their apartment recreation rooms and at schools. Our After-School Club has grown to more than 17 weekly participants. Additionally, we have attended a Wellness Fair at Searles Elementary in Union City and are hoping to have a future presence at that school and others with after school programs. This year we have interacted with 7 schools in the Fremont and Union City school districts.

A second obstacle we faced was reaching Afghan men who typically do not want to engage in counseling services. We started a monthly men's support group, a men's ESL class and held a Father's Day Celebration. We used these events to de-stigmatize Mental Health issues and promote overall wellbeing and encourage prevention services.

3. Please describe the innovative ways your program has weaved the topics of mental health/emotional well-being into your activities. Please give at least one example.

There are several ways our programs weaves the topics of mental health/emotional well-being into our activities through: art therapy, cultural events such as Barat and Nowruz, cooking lessons, jewelry making, sewing classes and reciting and creating poetry to name a few. The classes give our clients a safe place to learn a new skill, discover their creative side, share their personal stories and meet others in the community. The workshops are a vehicle for enhancing self-esteem and building community, both important ingredients for positive mental health.

At the Barat Celebration (Festival of Lights) our clients were invited to a night filled with food, raffles, dancing and a presentation by our Prevention Counselor on the importance of Self-Care during Ramadan. By creating a fun, inviting event people are more apt to come and learn about Wellness topics therefore increasing their knowledge about mental health and further breaking down the stigma. Clients are encouraged at these events to meet with our Prevention Counselor, Dr. Masoud Ghafoer, if they are experiencing any mental health issues and to participate in our support groups as a way to be connected to their community.

4. Please describe how your program has encouraged access to your services and your strategies for successful linkage for mental health treatment.

Our office is a one stop shop for many Afghan refugees and immigrants. Many times we see clients for the first time for reasons such as housing, employment and social services. An assessment is done at the first visit to the office. We determine what their needs are and refer them to different Afghan Coalition programs and community resources. Through our intake process we are able to discern who may benefit from preventative counseling and also refer clients to our on-going support groups. Through social media, community outreach events, Consortium Meetings and our youth program we encourage access to our Wellness Center.

Additionally, our partnerships with Afghan Community groups allow us to leverage our resources to provide outreach and engagement to our targeted population. Some of these outreach events include Poetry Night, Cultural Night and Soccer Night. Partners refer clients to our wellness programs through these events.

5. Describe how your program interacted with various other ACBH funded programs/projects such as school-based programs, other prevention programs, the stigma and discrimination reduction campaign, 10 x 10 campaigns etc.

We encouraged other agencies to attend our Consortium Meetings, which we consider one of the highlights of our program, so that we can train each other on cross cultural issues. We also referred people to other agencies when applicable and have shared information. In the future, we hope to schedule a site visits with other prevention programs as well as host them at our office as a means to provide a cross cultural training. Additionally, one of our goals for next year is to host an event with another UELP program.

This year we presented our program at Catholic Charities and participated in International Refugee in June.

6. What are your goals for your program for the upcoming fiscal year?

   1. Finding innovative ways to outreach and engage more Men in our targeted populations for mental health services.
   2. Partner with another UELP prevention program on an outreach event
   3. Continue to educate our community that having a mental health challenge is similar to a physical health challenge and to seek help sooner.
   4. Expand outreach efforts to reach more isolated people.
   5. Grow our youth program to include two more after school programs
   6. Establishing a weekly drop in meeting spot in Little Kabul, Fremont with outreach workers
   7. Family counseling for new refugee families to include effective and healthy parenting boundaries and communication for healthy relationships.

Access & Linkage to Mental Health Treatment (Question 1 and 3 are required per your Exhibit A - Quality Measures)

1. Number of individuals with serious mental illness (SMI) who received a paper referral (i.e. referrals via phone do not apply) from your program…
   a. To an ACBH-funded mental health treatment program: N/A
   b. To a non-ACBH-funded mental health treatment program: We made 6 (six) referrals to non-ACBF-funded agencies/mental health providers this Fiscal year.

2. List type(s) of mental health treatment programs the individual was referred to (i.e. outpatient, inpatient, etc.):

   Five individuals were referred to an outpatient program (psychologist) and one individual to an outpatient program at a non-profit agency for a psychological evaluation.

3. Number of individuals who were successfully referred and linked (i.e. client has been seen at least once in person by a treatment provider):
   a. To an ACBH mental health treatment program: N/A
   b. To a non-ACBH-funded mental health treatment program:

      Three clients were successfully referred and linked to the above mentioned providers.

4. Average duration in weeks of signs of untreated mental illness (per client self-report) *(write "n/a" or "unknown" when applicable): N/A*

5. Average time in weeks between when a paper referral was given to individual by your program and the individual's first in person appointment with a mental health treatment provider *(write "n/a" or "unknown" when applicable)*:

   The average time between a paper referral given to an individual by the Afghan Coalition and the individual's first in person appointment was approximately three weeks.

TIMELY ACCESS (TO OTHER PEI-FUNDED PROGRAMS)

1. Number of separate paper referrals to another ACBH **PEI-funded** program. *(write "n/a" or "unknown" when applicable)*: N/A

2. Number of individuals followed through on referral & engaged in an ACBH PEI-funded program *(write "n/a" or "unknown" when applicable)*: N/A

3. Average time in weeks between when a paper referral was given to individual by your program and the individual's first in person appointment with the ACBH PEI-funded provider*(write "n/a" or "unknown" when applicable)*: N/A

UELP Prevention Data Report FY 18/19

MHSA Program Number: PEI 7
Program Name: Outreach, Education & Consultation for South Asian/Afghan Community- Filipino Community Wellness Program

Filipino Community Wellness Program aims to engage young people, immigrants and low-wage workers in healthy, positive, culturally relevant, and inclusive activities that prevent isolation, disconnection, anxiety, fear and hopelessness, and reduces the stigmas associated with use of mental health services. Activities will focus on helping community members understand the twin impacts of colonial/post- colonial trauma and the marginalization of immigrants in the US on help-seeking behaviors. Services will be concentrated on Filipinos in the central and southern regions of Alameda County.

General Information & Total Numbers Served

Total Numbers Served through PEI MHSA		
Number of unduplicated individuals your program serves who are **at-risk** of developing a mental health problem or serious mental illness (SMI)	A	1,415
Number of unduplicated individuals your program serves who show **early signs** of forming a more severe mental illness	B	22
Number of unduplicated individual family members served indirectly by your program:	C	
Grand TOTAL of unduplicated individuals served in the Quarter that you are reporting about. [This number (D) should = A+B+C.]	D	1,437

DEMOGRAPHICS

Age Group (Unduplicated)	
Children/Youth (0-15)	42
Transition Age Youth (16-25)	1,103
Adult (26-59)	131
Older Adult (60+)	122
Unknown/ Declined to Answer	17

Race (Please mark only one choice) *If Hispanic or Latino, choose "Another race not listed."*	
American Indian or Alaska Native	
Asian	1,360
Black or African American	
Native Hawaiian or other Pacific Islander	
White	6
More than one race	
Another race not listed	34
Unknown/ Declined to Answer	4

Sexual Orientation (Please mark only one choice)	
Gay or Lesbian	25
Heterosexual or Straight	905
Bisexual	1
Questioning or unsure of sexual orientation	
Queer	
Another sexual orientation not listed	
Unknown/Decline to Answer	375

Ethnicity /Cultural Heritage (Please mark only once choice)	
If Hispanic or Latino, please specify:	
Caribbean	
Central American	
Mexican/Mexican--American/Chicano	1
Puerto Rican	
South American	
Another Hispanic/Latino ethnicity not listed	6
Unknown/Declined to Answer	
If Non-Hispanic or Non-Latino, please specify:	
African	
African American	
Asian Indian/South Asian	1
Cambodian	
Chinese	
Eastern European	
European	
Filipino	1,318
Japanese	
Korean	
Middle Eastern	
Vietnamese	24
Other Non-Hispanic or Non-Latino ethnicity not listed	
More than one ethnicity	
Unknown /Declined to Answer	

Primary Language (Please mark only one choice)	
English	1,201
Spanish	
Farsi	
Cantonese	
Mandarin	
Other Chinese Dialects	
Vietnamese	
Korean	
Tagalog	195
Other Filipino Dialect	
Japanese	
Laotian	
Cambodian	
Mien	
Hmong	
Samoan	
Thai	
Russian	
Polish	
German	
Italian	
Turkish	
Hebrew	
French	
Portuguese	
Armenian	
Arabic	
Sign ASL	
Other primary language not listed	19
Unknown/ Decline to Answer	

Gender Identity (Please mark both parts A &	
A) Assigned sex at birth: (Please mark only one choice)	
Male	539
Female	839
Other sex not listed (e.g. Intersex)	
Unknown/Decline to Answer	7
B) Current Gender Identity: (Please mark only one choice)	
Male	
Female	
Transgender	1
Genderqueer	
Questioning or Unsure of Gender Identity	
Another Gender Identity not listed	
Unknown/Decline to Answer	1,377

Disability Status (Please mark all that apply)	
None	455
Yes. If yes, please specify (choose from list below):	
Difficulty Seeing	
Difficulty hearing, or having speech understood	1
Mental Domain	1
Physical/Mobility Domain	20
Chronic Health Condition	26
Another disability not listed	
Unknown/Decline to Answer	912

Veteran Status (Please mark only one choice)	
Yes	
No	183
Unknown/Decline to Answer	1,232

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

PROGRAM OVERVIEW

1. What were the successes/accomplishments of the past year? Please provide one example or case study of a success your agency is particularly proud of.

Three support groups were initially provided: a high school-aged youth group began in July 2018; a transition-aged (TAY) group for adults 18 to 23 years old began in January 2019; and a low wage worker/caregiver support group that serves mainly elderly adults began in July 2018. A group for queer/LGBTQIA+ youth spun off in June 2019 and a young women's group will follow. Activities focused on around mental well-being and self-care. Outreach via social media was particularly effective for TAY. The low wage worker group was particularly responsive to the incorporation of art and movement into the psychoeducation workshops. For youth at James Logan High School in Union City, a structured referral system has been developed to link at-risk Filipino students to FAJ for preventative counseling services. Two of the adolescent clients who were provided individual preventative counseling services agreed to family counseling. The parents, very reluctant to receiving services, were invited to attend a few of the sessions. As a result, the parents realized their need for mental health support and requested to be seen separately for their own individual counseling.

2. What were the challenges and how did your agency mitigate challenges?

   - Challenges with program on-ramping prevented us from reaching our Preventative Counseling goals. Full staffing and strategic planning have resolved these issues going forward.
   - For TAY, challenges were mostly in attendance and having consistency in regular attendees for events. By building more strategies to do more in-person outreach on college campuses, resource fairs, and conferences, these challenges were slowly overcome. Consistency with follow-ups and check-ins with participants from each workshop/event improved attendance over time.
   - Elderly workers and caregivers often have transportation challenges. Rotating program locations in areas most convenient to participants helped mitigate this challenge.
   - For youth participants, challenges were mostly logistical. Securing regular meeting space at the school for workshops and meetings was made possible by strengthening relationships with administration to secure a multiyear MOU. Language barriers for immigrant youth were mitigated by providing space to express themselves in their preferred dialect. Materials, videos, pictures incorporated bilingual or in-language audio/words.
   - Finding a Tagalog-speaking mental health provider to triage with for non-English speaking Filipino clients who will require extensive and regular psychotherapy has been challenging. Filipino Advocates for Justice (FAJ) continues to collaborate with Asian Health Services for potential client referrals, and a translator will be hired to assist if needed.
   - The goal to de-stigmatize counseling and mental health posed some challenges in the beginning. Many of the Filipinos in the community appeared to have very little interest in participating at mental-health related events. FAJ reframed the concept of mental health and counseling to empower the community through psycho-education workshops on topics that are focused on self-care, stress management, and wellness.

3. Please describe the innovative ways your program has weaved the topics of mental health/emotional well-being into your activities. Please give at least one example.

   - Individual and group sessions circle back to mental health, such as stress relief practices, mindfulness workshops through creative/artistic outlets, activities that debunk daily stressors such as family, housing conditions, and financial stressors. We have also held recreational outings such as nature hikes to demonstrate the effect physical wellness has on mental health.
   - Participants saw the connection between their emotional well-being and challenging social conditions to help them understand their experiences in a holistic way.
   - Art and movement was incorporated into workshops to allow participants to better express themselves.

- Meditations were provided in Tagalog during workshops.
- We incorporated mental health stigma and societal norms into Filipino folklore to discuss ideas of empowerment, demonization, mental health and indigenous values
- We normalized discussion of oppressive cultural norms and healthy cultural values, leading to critical analysis of culture that does not frame Filipino culture as deficient, but a source of strength. Filipino culture seen as dynamic vs stagnant, something they have power over. They influence it as much as they have influence

4. Please describe how your program has encouraged access to your services and your strategies for successful linkage for mental health treatment.

- School campus and online/social media outreach has increased visibility of the program and available resources for youth and TAY populations.
- A partnership with the Department of Labor Standards and Enforcement provides referral of Filipino workers who need support in dealing with anxiety and other MH concerns.
- De-stigmatized seeking mental health resources via normalizing discussion around mental health in meetings and workshops
- Mental health and emotional stability were tied to indigenous values of *kapwa*, relating them to the collective health of community.
- Outreach workers provided monthly check-in/one-on-ones with peer leaders and other members, or as needed, normalizing help-seeking.
- Participants who required more in-depth preventative care were provided a warm hand-off to in house mental health specialist, acclimate them to seeing mental health professionals
- Relationships with schools' onsite health clinic and COST made for easy, efficient referrals.

5. Describe how your program interacted with various other ACBH funded programs/projects such as school-based programs, other prevention programs, the stigma and discrimination reduction campaign, 10 x 10 campaign etc.

- Participation in school site COST for program outreach and cross-referral.
- Provided consultations with other providers such as Union City Youth and Family Services.
- Provided access to existing SUD PPv clients who can benefit from preventative mental health counseling.
- Provided support pipeline for existing youth participants to TAY support groups.
- Collaborated with school counselors and health clinic for case management of youth?
- Participation of UELP staff in monthly trainings provided by Wellness in Action.

6. What are your goals for your program for the upcoming fiscal year?

- Expand the number of participants in TAY groups.
- Provide continued curriculum refinement for workshops and
- Increase collaborations with other providers and community stakeholders
- Provide male & female support youth sub-groups. Study and implement effective support strategies for non-binary and gender non-conforming participants.
- Replicate the systematic referral procedure developed at James Logan High School to other school sites.

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

ACCESS & LINKAGE TO MENTAL HEALTH TREATMENT (QUESTION 1 AND 3 ARE REQUIRED PER YOUR EXHIBIT A - QUALITY MEASURES)

1. Number of individuals with serious mental illness (SMI) or exhibit symptoms of a SMI who received a paper referral (i.e. referrals via phone do not apply) from your program…
    a. To an ACBH-funded mental health treatment program: 0
    b. To a non-ACBH-funded mental health treatment program: 0
2. List type(s) of mental health treatment programs the individual was referred to (i.e. outpatient, inpatient, etc.): n/a
3. Number of individuals who were successfully referred and linked (i.e. client has been seen at least once in person by a treatment provider):
    a. To an ACBH mental health treatment program: 0
    b. To a non-ACBH-funded mental health treatment program: 0
4. Average duration in weeks of signs of untreated mental illness (per client self-report) *(write "n/a" or "unknown" when applicable): n/a*
5. Average time in weeks between when a paper referral was given to individual by your program and the individual's first in person appointment with a mental health treatment provider *(write "n/a" or "unknown" when applicable)*: n/a

TIMELY ACCESS (TO OTHER PEI-FUNDED PROGRAMS)

1. Number of separate paper referrals to another ACBH **PEI-funded** program. *(write "n/a" or "unknown" when applicable)*: n/a
2. Number of individuals followed through on referral & engaged in an ACBH PEI-funded program *(write "n/a" or "unknown" when applicable)*: n/a
3. Average time in weeks between when a paper referral was given to individual by your program and the individual's first in person appointment with the ACBH PEI-funded provider*(write "n/a" or "unknown" when applicable)*: n/a

UELP Prevention Data Report FY 18/19

MHSA Program Number: PEI 7
Program Name: Outreach, Education & Consultation for South Asian/Afghan Community-Afghan Path toward Wellness (International Rescue Committee (IRC))

Afghan Path towards Wellness (APTW) : Providing wellness and psychosocial support services to the Afghan community of North Alameda County. Primary services include preventative counseling, psycho-educational and educational workshops, community events, socials support groups, wellness assessments, and community provider and leader trainings.

General Information & Total Numbers Served

Number of unduplicated individuals your program serves who are **at-risk** of developing a mental health problem or serious mental illness (SMI)	**A**	690
Number of unduplicated individuals your program serves who show **early signs** of forming a more severe mental illness	**B**	45
Number of unduplicated individual family members served indirectly by your program:	**C**	
Grand TOTAL of unduplicated individuals served in the Quarter that you are reporting about. [This number (D) should = A+B+C.]	**D**	735

Demographics

Age Group (Unduplicated)	
Children/Youth (0-15)	224
Transition Age Youth (16-25)	70
Adult (26-59)	395
Older Adult (60+)	1
Unknown/ Declined to Answer	

Race (Please mark only one choice) *If Hispanic or Latino, choose "Another race not listed."*	
American Indian or Alaska Native	
Asian	663
Black or African American	
Native Hawaiian or other Pacific Islander	
White	
More than one race	
Another race not listed	27
Unknown/ Declined to Answer	

Sexual Orientation (Please mark only one choice)	
Gay or Lesbian	
Heterosexual or Straight	586
Bisexual	
Questioning or unsure of sexual orientation	
Queer	
Another sexual orientation not listed	
Unknown/Decline to Answer	104

Ethnicity /Cultural Heritage (Please mark only once choice)	
If Hispanic or Latino, please specify:	
Caribbean	
Central American	
Mexican/Mexican--American/Chicano	14
Puerto Rican	
South American	
Another Hispanic/Latino ethnicity not listed	
Unknown/Declined to Answer	
If Non-Hispanic or Non-Latino, please specify:	
African	
African American	
Asian Indian/South Asian	
Cambodian	
Chinese	
Eastern European	
European	
Filipino	
Japanese	
Korean	
Middle Eastern	
Vietnamese	
Other Non-Hispanic or Non-Latino ethnicity not listed Afghan - 599 Burmese – 14 Other Asian/Pacific Islander - 33	646
More than one ethnicity	
Unknown /Declined to Answer	

Primary Language (Please mark only one choice)	
English	
Spanish	14
Farsi	40
Cantonese	
Mandarin	
Other Chinese Dialects	
Vietnamese	
Korean	
Tagalog	
Other Filipino Dialect	
Japanese	
Laotian	
Cambodian	
Mien	
Hmong	
Samoan	
Thai	
Russian	
Polish	
German	
Italian	
Turkish	
Hebrew	
French	
Portuguese	
Armenian	
Arabic	
Sign ASL	
Other primary language not listed Burmese – 30 Dari – 292 Pashto -266 Other -46	634
Unknown/ Decline to Answer	

Gender Identity (Please mark both parts A & B)	
A) Assigned sex at birth: (Please mark only one choice)	
Male	257
Female	433
Other sex not listed (e.g. Intersex)	
Unknown/Decline to Answer	
B) Current Gender Identity: (Please mark only one choice)	
Male	
Female	
Transgender	
Genderqueer	
Questioning or Unsure of Gender Identity	
Another Gender Identity not listed	
Unknown/Decline to Answer	690

Disability Status (Please mark all that apply)	
None	577
Yes. If yes, please specify (choose from list below):	
Difficulty Seeing	
Difficulty hearing, or having speech understood	
Mental Domain	
Physical/Mobility Domain	
Chronic Health Condition	
Another disability not listed	
Unknown/Decline to Answer	113

Veteran Status (Please mark only one choice)	
Yes	
No	690
Unknown/Decline to Answer	

PROGRAM OVERVIEW

1. What were the successes/accomplishments of the past year? Please provide one example or case study of a success your agency is particularly proud of.

   One particular client has significantly benefited from the wrap-around services offered by the IRC's Afghan Path towards Wellness program. This individual had been enrolled in IRC's intensive case management program prior to the start of our UELP project, but given her vast number of needs, still required additional support. APTW's preventative counselor was able to work with the client to identify her primary source of depression, which was an element of her living situation. The preventative counselor worked alongside the client to successfully advocate with her low-income housing unit to be transferred to a different apartment. Another need the client identified was social isolation. The preventative counselor was able to connect her to the Pathways to Wellness women's support group at Refugee Transitions (subcontractor), where she was able to meet and socialize with other women. While the client continues to work through her mental health needs with a licensed specialist, the client states that the holistic services offered to her under the Afghan Path towards Wellness program have done more to improve her social/emotional wellbeing than her psychiatrist was able to accomplish in over 2 years.

2. What were the challenges and how did your agency mitigate challenges?

   APTW faces the continued challenge of clients not being ready or willing to access formalized mental health care. In year one APTW focused on building connections with different providers in the area and established a concrete understanding of the referral process. The preventative counselor also focused on one-on-one coaching around the stigmatization of mental health and benefits of seeking mental health support services. The IRC looks forward to continuing this work into year 2 and believe that as more trust is established in the community, there will be correlated successes in referring clients to ACBH mental health providers.

   One challenge APTW faced, as is common with pilot projects, is that some of the interventions the program planned to utilize were not found to be effective. For example, according to IRC's initial proposal, APTW planned to implement the Refugee Health Screener-15 (RHS-15) document with all new clients in their first meeting with wellness promoters. The RHS-15 is a non-clinical assessment of depression, anxiety, and PTSD. The wellness promoters quickly learned that clients were not comfortable answering these intensive questions when they had not yet established substantial trust and rapport with the assessor. The Health & Wellness Manager therefore consulted with the county and agreed to adapt program implementation to include the possibility of utilizing the RHS-15 when appropriate, but to no longer mandate it upon intake.

3. Please describe the innovative ways your program has weaved the topics of mental health/emotional well-being into your activities. Please give at least one example.

   The IRC has utilized the Pathways to Wellness (P2W) support group curriculum to increase social support and connection, while simultaneously breaching the topic of mental health and emotional wellbeing. The IRC's P2W group and curriculum is modeled after an evidence-generating Pathways to Wellness project designed specifically for refugees by Lutheran Community Services Northwest, Asian Counseling and Referral Services, Public Health Seattle & King County, and Michael Hollifield, M.D. P2W is an adaptable and scalable model and it is currently being implemented across the U.S. These support groups increase social support systems, decrease isolation, promote personal empowerment of group members, and encourage health-promoting and coping behaviors. The eight-week community social adjustment support group focuses on acculturation issues and coping skills of clients, and builds off of the existing skills and qualities of the group participants to create change within themselves and their communities. The session topics are as follows:

   Week 1 – Introduction to the group
   Week 2 – Culture Shock

Week 3 – The Refugee Experience
Week 4 – Mental Health
Week 5 – The Mind & Body Connection
Week 6 – Goals and Dreams
Week 7 – Creating Wellness
Week 8 – Creating a Community of Wellness

We have found that the timing of the Mental Health and Mind & Body Connection sessions are ideal, as they allow the group to first gain a level of comfort with both each other and the facilitator. Of the three P2W cycles administered by the IRC prior to our UELP contract, 100% of participants who completed the cycle report feeling more adjusted to life in the U.S. and more connected to the community.

4. Please describe how your program has encouraged access to your services and your strategies for successful linkage for mental health treatment.

   In order to ensure clients and providers learn about the APTW Program, the Health & Wellness (H&W) team started internally by conducting a presentation to the full IRC staff on all of the different components of the program and the referral process. This ensured that any refugee or Special Immigrant Visa holder (SIV) who was enrolled in other IRC programming (case management, employment, ESL, immigration, etc.) and exhibiting signs of emotional stress would be referred to the H&W team. This same presentation has also been conducted with external partner providers. Additionally, the APTW team is present at the bi-weekly IRC Case Consultation meetings to inquire about potential referrals and offer support.

   IRC's partnership with the sub-contractor, Refugee Transitions (RT), has been invaluable. The Refugee Transitions team also advertises the program to partner providers and clients. RT conducts client wellness assessments at their office, and when an issue is identified, the team immediately makes a referral to the Health & Wellness Manager at IRC, who identifies the most appropriate APTW program(s) for the client in need.

   The APTW strategies for successful linkage to mental health treatment revolve around one-on-one coaching on resources, and education around myths of the risks of seeking mental health treatment. A common concern in the Afghan community is that if someone seeks mental health treatment, this may put them at risk with their employer, with CPS, and with other governmental agencies. The APTW preventative counselor works diligently with each client to dispel these myths and offer input on what mental health care truly looks like in the United States. If and when a client is willing to seek mental health treatment, the Preventative Counselor offers to accompany the client to the first session to support with transportation, registration, and other logistical stressors that can discourage someone from getting connected. Further, the APTW psycho-educational workshops aim to inform the Afghan community about different mental health and emotional support resources available to them, and to dispel myths about seeking such care.

5. Describe how your program interacted with various other ACBH funded programs/projects such as school-based programs, other prevention programs, the stigma and discrimination reduction campaign, 10 x 10 campaign etc.

   In year one of APTW, the IRC looked to other UELP PEI providers for their wisdom, guidance, and client support. We attended trainings health by the Afghan Coalition in Fremont – the veteran holder of the UELP PEI project for the Afghan Community of South Alameda County. We networked with their team members to learn about the challenges and successes they faced in implementing wellness programming. APTW also worked closely with the Oakland Unified School District to identify Afghan families who would be eligible for wellness programming.
   Two psycho-educational workshops were conducted within the school system to better reach these families and youth. Further, APTW connected directly with Multilingual Counseling, an ACBH-funded

specialty mental health provider with language capacity in Dari. Of the two successful mental health referrals APTW was able to make, one was connected with Multilingual Counseling.

6. What are your goals for your program for the upcoming fiscal year?

   In addition to our contract deliverables, the IRC's APTW project has the following goals for FY19-20:
   - Continue to decrease stigma associated with mental health in the Afghan community, and in turn, increase mental health referrals to ACBH providers.
   - Build deeper connections and referral systems with ACBH-funded providers
   - Expand the psycho-educational workshop curriculums and bring in more community experts to teach these sessions
   - Offer mental health skills trainings to the larger Oakland non-profit community, beyond our current partner base
   - Audio-record the mental health trainings offered by our clinical provider for posterity and the benefit of those who cannot attend in person.
   - Build stronger data-collection systems to evaluate the impact of APTW programming, as identified through client satisfaction surveys and wellness assessments.
   - Ensure client participants have a strong voice in communicating their wishes for program elements, structure, and adaptations.
   - Continue to respond not only to concrete mental health concerns, but also to other needs that impact social wellbeing

Access & Linkage to Mental Health Treatment (Question 1 and 3 are required per your Exhibit A - Quality Measures)

1. Number of individuals with serious mental illness (SMI) or exhibit symptoms of a SMI who received a paper referral (i.e. referrals via phone do not apply) from your program…
   a. To an ACBH-funded mental health treatment program: 2
   b. To a non-ACBH-funded mental health treatment program: 0

   This component of APTW's work was the most challenging in year one as the program is just beginning to address the stigma associated with seeking mental health support in the Afghan community. One outcome of note is that the Preventative Counselor has been able to successfully connect many clients to a Primary Care Doctor for depression and anxiety medication. Clients enrolled this fiscal year have been more willing to talk about their emotional stressors with a primary care doctor as opposed to a mental health clinician. The preventative counselor has worked with 6 clients who have successfully been prescribed an appropriate medication regiment through their PCP. Also of note is that 4 preventative counseling clients were already seeing specialty mental health providers when referred to us, but had identified that they needed additional, culturally relevant support to address all of their psychosocial needs.

2. List type(s) of mental health treatment programs the individual was referred to (i.e. outpatient, inpatient, etc.):
   Outpatient

3. Number of individuals who were successfully referred and linked (i.e. client has been seen at least once in person by a treatment provider):
   a. To an ACBH mental health treatment program: 1
   b. To a non-ACBH-funded mental health treatment program: 1

4. Average duration in weeks of signs of untreated mental illness (per client self-report) *(write "n/a" or "unknown" when applicable):* Unknown – we did not track this data in year one.

5. Average time in weeks between when a paper referral was given to individual by your program and the individual's first in person appointment with a mental health treatment provider *(write "n/a" or "unknown" when applicable)*: Unknown – we did not track this data in year one.

TIMELY ACCESS (TO OTHER PEI-FUNDED PROGRAMS)

1. Number of separate paper referrals to another ACBH **PEI-funded** program. *(write "n/a" or "unknown" when applicable)*: Unknown – we did not track this data in year one.

2. Number of individuals followed through on referral & engaged in an ACBH PEI-funded program *(write "n/a" or "unknown" when applicable)*: Unknown – we did not track this data in year one.

3. Average time in weeks between when a paper referral was given to individual by your program and the individual's first in person appointment with the ACBH PEI-funded provider*(write "n/a" or "unknown" when applicable)*: Unknown – we did not track this data in year one.

UELP Prevention Data Report FY 18/19

MHSA Program Number: PEI 7
Program Name: Outreach, Education & Consultation for South Asian/Afghan Community-
The Hume Center- South Asian Community Health Promotion Services Program

Every person experiences challenges at different stages in their life, such as falling in love, marriage, divorce, parenting, the developmental challenges following the birth of a child, a child's first day of school, work relationships, aging, and retirement. Other types of challenges can be unpredictable, such as accidents and sicknesses. Working with the South Asian population has shown us that these challenges may increase remarkably if you are an immigrant. In order to help people cope with such challenges successfully, The Hume Center has developed the South Asian Community Health Promotion Services Program.

This program provides short term, culturally sensitive and language specific services aimed at developing knowledge and skills to work through life challenges effectively. These services are provided not only at our clinic but we have the flexibility of providing home visits and of offering services at schools, religious establishments and other community locations. These services include prevention, preventative counseling, workshops and presentations. In order to address the significant amount of stigma around emotional wellness this program also provides outreach in the community to educate and increase utilization of services by the South Asian Community.

General Information & Total Numbers Served

Total Numbers Served through PEI MHSA		
Number of unduplicated individuals your program serves who are **at-risk** of developing a mental health problem or serious mental illness (SMI)	**A**	96
Number of unduplicated individuals your program serves who show **early signs** of forming a more severe mental illness	**B**	6,502
Number of unduplicated individual family members served indirectly by your program:	**C**	
Grand TOTAL of unduplicated individuals served in the Quarter that you are reporting about. [This number (D) should = A+B+C.]	**D**	6,598

DEMOGRAPHICS

Age Group (Unduplicated)	
Children/Youth (0-15)	
Transition Age Youth (16-25)	
Adult (26-59)	
Older Adult (60+)	
Unknown/ Declined to Answer	

Race (Please mark only one choice) *If Hispanic or Latino, choose "Another race not listed."*	
American Indian or Alaska Native	3
Asian	
Black or African American	
Native Hawaiian or other Pacific Islander	
White	
More than one race	
Another race not listed	
Unknown/ Declined to Answer	

Sexual Orientation (Please mark only one choice)	
Gay or Lesbian	1
Heterosexual or Straight	1,611
Bisexual	5
Questioning or unsure of sexual orientation	
Queer	
Another sexual orientation not listed	
Unknown/Decline to Answer	4,885

Ethnicity /Cultural Heritage (Please mark only once choice)	
If Hispanic or Latino, please specify:	
Caribbean	
Central American	
Mexican/Mexican--American/Chicano	
Puerto Rican	
South American	
Another Hispanic/Latino ethnicity not listed	209
Unknown/Declined to Answer	
If Non-Hispanic or Non-Latino, please specify:	
African	
African American	
Asian Indian/South Asian	697
Cambodian	
Chinese	
Eastern European	
European	
Filipino	75
Japanese	
Korean	6
Middle Eastern	
Vietnamese	
Other Non-Hispanic or Non-Latino ethnicity not listed Afghan – 93 Asian Pacific Islander – 8 Bangladeshi – 8 Bhutanese 984 Nepalese – 1590 Pakistani – 16 Persian Iranian – 16 Other Asian – 124 Other South Asian – 526 Other South East Asian - 8	3,373
More than one ethnicity	
Unknown /Declined to Answer	

Primary Language (Please mark only one choice)	
English	3,639
Spanish	
Farsi	66
Cantonese	
Mandarin	
Other Chinese Dialects	
Vietnamese	
Korean	
Tagalog	
Other Filipino Dialect	
Japanese	
Laotian	
Cambodian	
Mien	
Hmong	
Samoan	
Thai	
Russian	
Polish	
German	
Italian	
Turkish	
Hebrew	
French	
Portuguese	
Armenian	
Arabic	
Sign ASL	
Other primary language not listed Hindi – 27 Punjabi – 185 Other - 2575	2,787
Unknown/ Decline to Answer	

Gender Identity (Please mark both parts A & B)	
A) Assigned sex at birth: (Please mark only one choice)	
Male	2,792
Female	3,196
Other sex not listed (e.g. Intersex)	
Unknown/Decline to Answer	512
B) Current Gender Identity: (Please mark only one choice)	
Male	
Female	
Transgender	2
Genderqueer	
Questioning or Unsure of Gender Identity	
Another Gender Identity not listed	
Unknown/Decline to Answer	6,500

Disability Status (Please mark all that apply)	
None	1,615
Yes. If yes, please specify (choose from list below):	
Difficulty Seeing	
Difficulty hearing, or having speech understood	
Mental Domain	
Physical/Mobility Domain	13
Chronic Health Condition	
Another disability not listed	1
Unknown/Decline to Answer	4,873

Veteran Status (Please mark only one choice)	
Yes	
No	1,827
Unknown/Decline to Answer	6,502

PROGRAM OVERVIEW

1. What were the successes/accomplishments of the past year? Please provide one example or case study of a success your agency is particularly proud of.
   This year we piloted our expansion to North County and our focus on the underserved Nepalese and Bhutanese communities by hiring outreach workers. We identified many successes out in North County such as the implementation of 6 different support groups focused on decreasing social isolation, addressing trauma related to immigration, and promoting youth leadership.

2. What were the challenges and how did your agency mitigate challenges?
   The biggest challenge we faced was also related to our expansion to North County. We struggled with staffing in regards to hiring a mental health consultant to provide Preventative Counseling to participants that were referred by our outreach workers. The struggle was that there was a specific language need and there was no one qualified to provide preventative counseling who also spoke Nepali. The outreach workers struggled to build rapport with community members due to the long wait list for Preventative Counseling. By identifying that many members of the Nepalese community speak Hindi we were able to mitigate the challenge towards the end of the fiscal year by having a Hindi speaking clinician provide the preventative counseling services. For 2019-2020 fiscal year we are also on boarding a Hindi speaking clinician that will be able to provide Preventative Counseling.

3. Please describe the innovative ways your program has weaved the topics of mental health/emotional well-being into your activities. Please give at least one example.
   This year we introduced some displays that talk about the Myths of Mental Health within the South Asian Community. When we display these myths on the table during outreach events, it allows community members to read and process from afar. We have offered a lot of take-away items at our outreach table that focus on coping strategies, parenting as immigrants, self-care, addressing suicide, and introducing emotional wellness phone apps to download. Talking about these things out in the open is not safe but reading it and thinking about it still allows them to learn without feeling exposed to their community.

   We have also utilized cultural and religious practices within our work with participants by making them a part of their wellness plan. Building on what they are already utilizing, rather than trying to introduce new ways of coping has really helped engage the community. For example, we offered a Chai group for Women and a Soccer Group for Bhutanese Men.

4. Please describe how your program has encouraged access to your services and your strategies for successful linkage for mental health treatment.
   The program has eliminated psychologically heavy language from their literature. Providers also refrain from using diagnostic terminology or psychological jargon when engaging with community members. For example, we refer to someone being extremely sad or extremely worried rather than saying the person is depressed or the person has anxiety. By helping the community focus on symptoms rather than diagnosis we help them normalize their experiences and decrease their feelings of hopelessness. Being able to work with individuals for up to a year allows us to build rapport with the participants to a point where we are able to help them link to other resources and often times even continue to work with them until they are fully linked and utilizing other resources. We have an internal outpatient program which allows it to be even easier to link to mental health treatment. Although the challenge has been that there are little to no linguistically or culturally appropriate providers in outpatient programs that meet our participant's needs.

5. Describe how your program interacted with various other ACBH funded programs/projects such as school-based programs, other prevention programs, the stigma and discrimination reduction campaign, 10 x 10 campaign etc.

   We collaborated with other ACBH funded programs and worked closely with school based programs at the different school campuses that we were at by providing mental health consultations and collaborating on school based events. We worked with other prevention programs to help refer participants that would benefit from their services based off their cultural/linguistic needs (Ex. Referring Chinese identified students to ARISE- Asian Wellness Project). We work with a lot of South Asian Domestic and Family Violence organizations in the area that also receive some funding from ACBH. We also work closely with Tri-City Health to help support the emotional needs of their South Asian participants.

6. What are your goals for your program for the upcoming fiscal year?

   Our goals this year are to continue to grow our services in North County and provide more consistency in having a Preventative Counseling provider available to participants needing the higher level of care. We have also expanded in South County by providing services at more schools in Fremont and Union City that have expressed a high level of stress in their South Asian student body. We hope to work more collaboratively with other CBO's and UELP Providers in the area to provide joint events that are focused on Prevention and Early Intervention. We are working on a project to help target parts of the South Asian community that we have not been able to engage in the past such due to high levels of stigma (ex. the elderly and South Asian Men) by hosting more culturally appropriate events. We are also beginning to provide some services in Pleasanton and Dublin and hope to be more visible county wide.

Access & Linkage to Mental Health Treatment (Question 1 and 3 are required per your Exhibit A - Quality Measures)

1. Number of individuals with serious mental illness (SMI) or exhibit symptoms of a SMI who received a paper referral (i.e. referrals via phone do not apply) from your program…
   a. To an ACBH-funded mental health treatment program: *unknown*
   b. To a non-ACBH-funded mental health treatment program: *unknown*

2. List type(s) of mental health treatment programs the individual was referred to (i.e. outpatient, inpatient, etc.):

3. Number of individuals who were successfully referred and linked (i.e. client has been seen at least once in person by a treatment provider):
   a. To an ACBH mental health treatment program: *N/a*
   b. To a non-ACBH-funded mental health treatment program: *3*

4. Average duration in weeks of signs of untreated mental illness (per client self-report) *(write "n/a" or "unknown" when applicable): On average participants have reported having signs for at least 6 months or more before they have engaged in services of any kind.*

5. Average time in weeks between when a paper referral was given to individual by your program and the individual's first in person appointment with a mental health treatment provider *(write "n/a" or "unknown" when applicable)*: *unknown*

Timely Access (to other PEI-funded programs)

1. Number of separate paper referrals to another ACBH **PEI-funded** program. *(write "n/a" or "unknown" when applicable)*: *unknown*

2. Number of individuals followed through on referral & engaged in an ACBH PEI-funded program *(write "n/a" or "unknown" when applicable)*: *unknown*

3. Average time in weeks between when a paper referral was given to individual by your program and the individual's first in person appointment with the ACBH PEI-funded provider*(write "n/a" or "unknown" when applicable)*: *unknown*

UELP Prevention Data Report FY 18/19

MHSA Program Number: PEI 8
Program Name: Outreach, Education & Consultation for Native American Community-Native American Health Center (NAHC)

Native American Health Center, Inc. (NAHC) - Native American Health Center provides culturally responsive mental health services; including preventative counseling, cultural prevention groups, outreach, psycho-education, community events, trainings, and referrals. NAHC targets Native American youth and adult populations living in Alameda County.

General Information & Total Numbers Served

Total Numbers Served through PEI MHSA		
Number of unduplicated individuals your program serves who are **at-risk** of developing a mental health problem or serious mental illness (SMI)	**A**	1,478
Number of unduplicated individuals your program serves who show **early signs** of forming a more severe mental illness	**B**	46
Number of unduplicated individual family members served indirectly by your program:	**C**	
Grand TOTAL of unduplicated individuals served in the Quarter that you are reporting about. [This number (D) should = A+B+C.]	**D**	1,524

DEMOGRAPHICS

Age Group (Unduplicated)	
Children/Youth (0-15)	161
Transition Age Youth (16-25)	106
Adult (26-59)	449
Older Adult (60+)	513
Unknown/ Declined to Answer	249

Race (Please mark only one choice) *If Hispanic or Latino, choose "Another race not listed."*	
American Indian or Alaska Native	705
Asian	96
Black or African American	71
Native Hawaiian or other Pacific Islander	
White	45
More than one race	
Another race not listed	285
Unknown/ Declined to Answer	276

Ethnicity /Cultural Heritage (Please mark only once choice)	
If Hispanic or Latino, please specify:	
Caribbean	
Central American	
Mexican/Mexican--American/Chicano	
Puerto Rican	
South American	
Another Hispanic/Latino ethnicity not listed	
Unknown/Declined to Answer	
If Non-Hispanic or Non-Latino, please specify:	
African	
African American	
Asian Indian/South Asian	
Cambodian	
Chinese	
Eastern European	
European	
Filipino	
Japanese	
Korean	
Middle Eastern	
Vietnamese	
Other Non-Hispanic or Non-Latino ethnicity not listed	256
More than one ethnicity	
Unknown /Declined to Answer	

Sexual Orientation (Please mark only one choice)	
Gay or Lesbian	49
Heterosexual or Straight	848
Bisexual	1
Questioning or unsure of sexual orientation	
Queer	
Another sexual orientation not listed	
Unknown/Decline to Answer	580

Primary Language (Please mark only one choice)	
English	1,452
Spanish	24
Farsi	
Cantonese	
Mandarin	
Other Chinese Dialects	
Vietnamese	
Korean	
Tagalog	
Other Filipino Dialect	
Japanese	
Laotian	
Cambodian	
Mien	
Hmong	
Samoan	
Thai	
Russian	
Polish	
German	
Italian	
Turkish	
Hebrew	
French	
Portuguese	
Armenian	
Arabic	
Sign ASL	
Other primary language not listed	
Unknown/ Decline to Answer	

Gender Identity (Please mark both parts A & B)	
A) Assigned sex at birth: (Please mark only one choice)	
Male	402
Female	816
Other sex not listed (e.g. Intersex)	
Unknown/Decline to Answer	260
B) Current Gender Identity: (Please mark only one choice)	
Male	402
Female	816
Transgender	
Genderqueer	
Questioning or Unsure of Gender Identity	
Another Gender Identity not listed	
Unknown/Decline to Answer	260

Disability Status (Please mark all that apply)	
None	905
Yes. If yes, please specify (choose from list below):	
Difficulty Seeing	
Difficulty hearing, or having speech understood	9
Mental Domain	6
Physical/Mobility Domain	67
Chronic Health Condition	
Another disability not listed	1
Unknown/Decline to Answer	490

Veteran Status (Please mark only one choice)	
Yes	47
No	1,124
Unknown/Decline to Answer	307

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

PROGRAM OVERVIEW

1. What were the successes/accomplishments of the past year? Please provide one example or case study of a success your agency is particularly proud of.

   The NAHC was proud to have accomplished all of its program goals over the past fiscal year. One specific case study example that staff felt particularly strong about I the case of a 13 year old Native Youth (Mixed w/African American ancestry). This youth entered our program having recently lost her mother. She experienced a great deal of trauma in her life, and witnessed a great deal of violence in her community. Being an Urban Native American of mixed descent, she did not know much of her Native culture. Through the AC PEI program, she was able to be screened and connected to our Mental Health Specialist (Alaska Native) who participated in counseling, and was taught to complete a cultural genogram, how to smudge, and was introduced to certain ceremonies. After participating in services, she reported feeling less depressed, felt closure from her mother's passing, and felt connected to the Native Community. She was referred to our Youth Services program and is currently in the process of registering for participation.

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2. What were the challenges and how did your agency mitigate challenges?

An early challenge we experienced was with indigenous youth and other community members feeling uncomfortable completing the language used on the consent form for preventative counseling. After meeting with County staff, we were able to develop language that met the County's needs, and was easily understandable to the community which increased our number of registered members.

3. Please describe the innovative ways your program has weaved the topics of mental health/emotional well-being into your activities. Please give at least one example.

NAHC's UELP Program weaves the topics of mental health into all cultural activities and community events, either by directly having a Mental Health specialist attending the event, communicating the importance and availability of mental health services, or by taking opportunities during activities to have one-to –one brief interventions. One example of this was during our Spring Gathering Event. During this event, community members gathered at the Alameda Crown Beach to celebrate the spring season and share a meal together. During the event, a traditional healer (Arnita "Grandma" Swanson) was on hand to do a traditional Native American song, prayer, and talking circle, while Behavioral Health clinicians were present to reduce the stigma of receiving Mental Health services. The clinicians and community health workers participated in in activities such as catch, flying kites, and Frisbee with youth, adults, and their families.

4. Please describe how your program has encouraged access to your services and your strategies for successful linkage for mental health treatment.

NAHC's PEI Program has encouraged access to our services and Mental Health treatment by including mental health providers in our cultural groups, community events, and workshops. At each group, a mental health topic is discussed, or information about Behavioral Health services are disseminated. Community events focus on youth or adult community members and include mental health service providers in order to build trust and familiarity between the community and staff. Our Community Health Workers also community members through intake/screening and discuss prevention services as well as treatment services if needed with each member.

5. Describe how your program interacted with various other ACBH funded programs/projects such as school-based programs, other prevention programs, the stigma and discrimination reduction campaign, 10 x 10 campaign etc.

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

NAHC's PEI Program provided prevention groups at the Oakland Unified School District sites in collaboration with our School Based health Center programs in the form of a Young Women's group facilitated by our Community Health Worker. We also provided training on our PEI program to the Alameda County UELP providers at a quarterly UELP Providers meeting to inform partners regarding our program.

6. What are your goals for your program for the upcoming fiscal year?

In the upcoming fiscal year, our program goal is to better coordinate and collaborate services with our Native American community partner agencies, as well as our fellow UELP Service providers. This will expand our potential reach, and assist us in contacting more community members.

ACCESS & LINKAGE TO MENTAL HEALTH TREATMENT (QUESTION 1 AND 3 ARE REQUIRED PER YOUR EXHIBIT A - QUALITY MEASURES)

1. Number of individuals with serious mental illness (SMI) or exhibit symptoms of a SMI who received a paper referral (i.e. referrals via phone do not apply) from your program…
   a. To an ACBH-funded mental health treatment program: 46
   b. To a non-ACBH-funded mental health treatment program: 12

2. List type(s) of mental health treatment programs the individual was referred to (i.e. outpatient, inpatient, etc.):
   MHS Referrals, Outpatient Preventative Counseling, Outreach, Stigma Reduction, Suicide Prevention, Education & Consultations**.**

3. Number of individuals who were successfully referred and linked (i.e. client has been seen at least once in person by a treatment provider):
   a. To an ACBH mental health treatment program: 46
   b. To a non-ACBH-funded mental health treatment program: Unknown

4. Average duration in weeks of signs of untreated mental illness (per client self-report) *(write "n/a" or "unknown" when applicable):* Unknown

5. Average time in weeks between when a paper referral was given to individual by your program and the individual's first in person appointment with a mental health treatment provider *(write "n/a" or "unknown" when applicable)*: Referrals typically take 24 hours for system to process, and appointments are scheduled for the following week.

TIMELY ACCESS (TO OTHER PEI-FUNDED PROGRAMS)

1. Number of separate paper referrals to another ACBH **PEI-funded** program. *(write "n/a" or "unknown" when applicable)*: Unknown

2. Number of individuals followed through on referral & engaged in an ACBH PEI-funded program *(write "n/a" or "unknown" when applicable)*: 46

3. Average time in weeks between when a paper referral was given to individual by your program and the individual's first in person appointment with the ACBH PEI-funded provider *(write "n/a" or "unknown" when applicable)*: The average time between a referral and an individual's first appointment is 1 week.

UELP Prevention Data Report FY 18/19

MHSA Program Number: PEI 10
Program Name: Outreach, Education & Consultation for Partnerships for African Community
Partnership for Trauma Recovery (PTR)

Partnerships for Trauma Recovery (PTR) provides culturally reflective, trauma-informed, linguistically competent and accessible UELP PEI services to the specific underserved population of forcibly displaced children, youth, adults, and families from African countries currently residing in North and South Alameda County. PTR specializes in providing holistic care, including culturally-reflective, trauma-informed behavioral health care and case management support for those who have fled violence and persecution in their home countries and seek refuge in the Bay Area. When entire societies are affected by large-scale violence such as war and genocide, collective trauma can result. Thus, mental health concerns caused by exposure to trauma are chief among the mental health needs for the priority population, and are PTR's primary focus. Intervening early and effectively once refugees and asylum-seekers reach the U.S. is key to preventing the deleterious effects of trauma from deeply impacting the lives of future generations. PTR has served adults, families, and youth from the African countries of Cameroon, Eritrea, Ethiopia, Nigeria, DR Congo, Uganda, Kenya, Mali, Senegal, Sudan, Egypt, Burkina Faso, and the Ivory Coast.

General Information & Total Numbers Served

Total Numbers Served through PEI MHSA		
Number of unduplicated individuals your program serves who are **at-risk** of developing a mental health problem or serious mental illness (SMI)	**A**	900
Number of unduplicated individuals your program serves who show **early signs** of forming a more severe mental illness	**B**	56
Number of unduplicated individual family members served indirectly by your program:	**C**	
Grand TOTAL of unduplicated individuals served in the Quarter that you are reporting about. [This number (D) should = A+B+C.]	**D**	956

DEMOGRAPHICS

Age Group (Unduplicated)	
Children/Youth (0-15)	82
Transition Age Youth (16-25)	175
Adult (26-59)	505
Older Adult (60+)	128
Unknown/ Declined to Answer	10

Race (Please mark only one choice) *If Hispanic or Latino, choose "Another race not listed."*	
American Indian or Alaska Native	1
Asian	65
Black or African American	576
Native Hawaiian or other Pacific Islander	
White	60
More than one race	
Another race not listed	198
Unknown/ Declined to Answer	

Sexual Orientation (Please mark only one choice)	
Gay or Lesbian	21
Heterosexual or Straight	233
Bisexual	3
Questioning or unsure of sexual orientation	
Queer	
Another sexual orientation not listed	
Unknown/Decline to Answer	643

Ethnicity /Cultural Heritage (Please mark only once choice)	
If Hispanic or Latino, please specify:	
Caribbean	
Central American	3
Mexican/Mexican--American/Chicano	2
Puerto Rican	
South American	1
Another Hispanic/Latino ethnicity not listed	85
Unknown/Declined to Answer	
If Non-Hispanic or Non-Latino, please specify:	
African	
African American	
Asian Indian/South Asian	30
Cambodian	
Chinese	4
Eastern European	
European	
Filipino	
Japanese	
Korean	1
Middle Eastern	
Vietnamese	
Other Non-Hispanic or Non-Latino ethnicity not listed Afghan – 4 Other Asian Pacific Islander – 25 Persian Iranian - 1	30
More than one ethnicity	
Unknown /Declined to Answer	

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

Primary Language (Please mark only one choice)	
English	391
Spanish	56
Farsi	
Cantonese	
Mandarin	
Other Chinese Dialects	
Vietnamese	
Korean	
Tagalog	
Other Filipino Dialect	
Japanese	
Laotian	
Cambodian	
Mien	
Hmong	
Samoan	
Thai	
Russian	
Polish	
German	
Italian	
Turkish	
Hebrew	
French	
Portuguese	
Armenian	
Arabic	3
Sign ASL	
Other primary language not listed Arabic – 3 Other - 449	452
Unknown/ Decline to Answer	

Gender Identity (Please mark both parts A & B)	
A) Assigned sex at birth: (Please mark only one choice)	
Male	416
Female	478
Other sex not listed (e.g. Intersex)	
Unknown/Decline to Answer	5
B) Current Gender Identity: (Please mark only one choice)	
Male	416
Female	478
Transgender	
Genderqueer	
Questioning or Unsure of Gender Identity	
Another Gender Identity not listed	
Unknown/Decline to Answer	5

Disability Status (Please mark all that apply)	
None	
Yes. If yes, please specify (choose from list below):	
Difficulty Seeing	
Difficulty hearing, or having speech understood	
Mental Domain	
Physical/Mobility Domain	4
Chronic Health Condition	
Another disability not listed	
Unknown/Decline to Answer	896

Veteran Status (Please mark only one choice)	
Yes	
No	
Unknown/Decline to Answer	900

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

PROGRAM OVERVIEW

1. What were the successes/accomplishments of the past year? Please provide one example or case study of a success your agency is particularly proud of.

   Over the past year, PTR's UELP PEI program provided preventive counseling to 56 unique clients, provided 133 prevention visits, facilitated 12 monthly psychoeducational workshops, conducted 3 educational workshops, facilitated 3 support groups, participated in 9 community events, and distributed our UELP PEI material on 5 local listservs that reach individuals and community-based organizations throughout the San Francisco Bay Area. PTR is particularly proud of our ability to facilitate monthly psychoeducational workshops that address practical needs of the community while incorporating wellness, self-care, and mental health awareness.

   One success we would like to highlight was the facilitation of a 9-week support group with 8 African boys who attend a local public high school. The group covered topics such as expressing and managing emotions; race and racism; and healthy communication. Overall, participants from the group reported a decrease in feelings of distress. After the end of the group, one student shared, "I feel like I was in prison since I didn't have friends and nowhere to go. And now I feel like I am liberated and happy since I make many friends from this group. I have fun and spend time with them even outside of the school."

2. What were the challenges and how did your agency mitigate challenges?

   The primary challenge PTR experienced pertained to the requirement to enter personal information in the county-wide InSyst system. The majority of our clients are asylum seekers, asylees, and refugees, many of whose status is currently uncertain. This is particularly the case for asylum seekers, whose cases may not be heard for several years. Given their past histories of trauma, their persecution often at the hands of government, and their insecure legal status, consenting to have their personal information reported in InSyst caused stress and anxiety. We addressed this challenge by allowing those clients who did not feel comfortable consenting to sharing their information in InSyst to continue to receive preventive counseling services, despite our ability to report of these clients in our total clients served (please see the table below for more information). Additionally, we have created a unique consent form for UELP PEI clients—separate from the consent form that all PTR clients receive—that clearly indicates the information that is shared in InSyst and the level of protection guaranteed by Alameda County to maintain confidentiality of all PHI. This new consent form—which will be implemented in FY 19-20—allows each UELP PEI client to be fully informed of the system and given the right to choose if they wish to consent to have their information entered in InSyst. We anticipate that this new process will enable us to vastly increase the number of clients who are opened in InSyst, and subsequently allow us to report on these clients who are receiving services under the UELP PEI program.

   Regarding other UELP activities, a challenge we experienced was working with African communities that expressed reluctance to seek mental health support based on a traditionally western model of care. We found our psychoeducational workshops to be more widely accepted if we incorporated practical issues—for example: housing, employment, or nutrition—with concepts related to wellness and self-care. We adapted our language to include a focus on wellness and self-care, rather than *mental health*, to be more culturally appropriate within the African communities we serve.

3. Please describe the innovative ways your program has weaved the topics of mental health/emotional well-being into your activities. Please give at least one example.

   As mentioned above, it was more culturally appropriate to discuss wellbeing and self-care, versus using language such as 'mental health' with the communities we served. In all of our activities we integrated a wellness component.

For example, our monthly psychoeducational workshops focused on practical topics important within the community, such as employment, housing, nutrition, exercise, assimilation, and parenting. During each of these monthly workshops, the workshop facilitators weaved in a wellness component by clearly demonstrating how the topic being covered related to stress, anxiety, wellness, and self-care. One example is a psychoeducational workshop held in February 2019, whereby guest speakers from Burma Refugee and Family Network and Centro Legal de la Raza provided information on affordable housing and tenants' rights. Following the information provided by the guest speakers, the African Communities Liaisons (Outreach Workers) discussed the ways stress caused by housing instability affect overall wellbeing and provided self-care techniques, such a movement and breathing exercises, to mitigate feelings of stress and anxiety. We found that incorporating somatic experiences to help connect mind and body were very successful with the participants of our workshops.

4. Please describe how your program has encouraged access to your services and your strategies for successful linkage for mental health treatment.

   Access to services can be a challenge for some members of African communities, due to services not being offered in diverse languages or culturally appropriate ways. Additionally, there are practical challenges, such as event location and cost of transportation that also play a role in the ability for individuals to seek and receive services. PTR encourages access to our services by offering psychoeducational workshops, support groups, and preventive counseling services in languages spoken by the community. In addition to the diverse language capacity of our African Communities Liaisons and clinical staff, PTR's Refugee Voices Interpreter Coordinator recruits, trains, and supervises mental health interpreters who speak the languages of our clients to provide interpretation for psychoeducational workshops, support groups, and preventive counseling sessions. PTR also translated our electronic and hard copy materials into several different languages to reach different segments of the community who do not speak English. The material was also adapted so that it could be well understood by youth, elderly, women, men, as well as those with or without formal education.

   During this past year, our psychoeducational workshops were offered at different locations throughout the community, on different days of the week, and during different times in an effort to make them accessible to members of the community who live throughout the county and who have varying schedules. We also offered to cover the costs of transportation to and from our events for our low-income clients who could not otherwise afford the cost of travel. Additionally, psychoeducational workshop topics were tailored to the community needs and demands in order to increase their participation and access to service provision. PTR's African Communities Liaisons and clinical staff distributed survey questions to the community members, and discussed with community and religious leaders to identify the needs of the community members before conducting the workshops. Thus, as per the community feedback and suggestions, PTR tried to address different mental health issues by integrating causes of stress/stressors such as immigration issues, employment, housing, parenting, and acculturation into the workshop material. Lastly, PTR has also used language and terms that are culturally appropriate and relevant in discussing mental health issues, such as referring to our psychoeducational workshops as African Communities Gathering, talking about *wellness* rather than *mental health* issues, and when appropriate, using terms such as mental health *issues* or mental health *concerns* opposed to talking about mental *illness*.

5. Describe how your program interacted with various other ACBH funded programs/projects such as school-based programs, other prevention programs, the stigma and discrimination reduction campaign, 10 x 10 campaign etc.

   PTR's has interacted with other ACBH-funded programs through outreach activities, school-based support group interventions, community outreach events, and information dissemination that helps to reduce the stigma and discrimination against people living with mental health issues.

PTR adopted different best practices and resources—such as support group and psychoeducational workshop manuals and curriculums that incorporate different approaches and strategies to promote mental health—from ACBH-funded, as well as non-ACBH-funded, partner organizations. In addition, PTR shared psychoeducational invitation flyers at East Bay Refugee Forum and SF-CAIRs to all partner organizations working on mental health, and some ACBH-funded partner organizations sent their staff to share experiences and participate in PTR-facilitated workshops. For instance, during an affordable housing and stress management psychoeducational workshop, two staff from the IRC UELP PEI program participated. PTR also interacted with and collaborated closely with ACBH-funded partners for different community outreach activities, including for community-based events, cultural events, wellness activities, and referrals throughout the program cycle.

6. What are your goals for your program for the upcoming fiscal year?

   PTR plans to continue to provide culturally responsive, strengths-based mental health outreach and education—through the provision of psychoeducational workshops, support groups, and educational workshops—as well as preventive counseling sessions and prevention visits to African communities residing in Alameda County. Our first year as a UELP PEI provider proved to be successful in many areas, and we have identified areas we are actively working to improve and expand. Specifically, a goal for the upcoming fiscal year is to expand our services to reach more culturally and ethnically diverse African communities. After receiving feedback from the communities we serve, we are planning to provide educational workshops to community leaders, such as in churches and mosques or different African Associations, so that these leaders feel more equipped to know how to respond if one of their members is experiencing mental health challenges. This will also provide us with the opportunity to increase collaboration with community stakeholders and organizations that serve African communities, while building the individual, community, and organizational capacity, knowledge, and skills that contribute to the prevention of mental health disorders.

   In addition, we also have a goal to expand our reach with younger African community members by including youth, both boys and girls, in and out of school, through a parent-inclusive approach to providing educational and supportive groups. We are also actively seeking more collaborative activities with other PEI programs during this upcoming fiscal year to increase the reach of our UELP PEI program.

   Our outreach efforts will continue to work toward decreasing the stigma and discrimination toward individuals experiencing mental health issues by providing timely access to related information, services, and support to African communities. We intend to integrate healing activities, such as sewing, beading, or other art activities, into our psychoeducational workshops and community events. Additionally, we have hired a new Mental Health Specialist to support our UELP PEI program during the upcoming fiscal year. This clinician will have the capacity to more actively participate in outreach activities, engage with community leaders, and attend monthly psychoeducational workshops. Her presence within the communities and at the psychoeducational workshops will help clients feel more comfortable seeking mental health support if additional support is needed. Greater access to our Mental Health Specialist, as well as improvements to our referral process for PEI counseling, will help to prevent mental illness from becoming severe and disabling.

Access & Linkage to Mental Health Treatment (Question 1 and 3 are required per your Exhibit A - Quality Measures)

1. Number of individuals with serious mental illness (SMI) or exhibit symptoms of a SMI who received a paper referral (i.e. referrals via phone do not apply) from your program…
   a. To an ACBH-funded mental health treatment program: 0
   b. To a non-ACBH-funded mental health treatment program: 8

2. List type(s) of mental health treatment programs the individual was referred to (i.e. outpatient, inpatient, etc.):

   PTR's preventive counseling clients are referred to Mental Health treatment services when their mental health symptoms are too severe for prevention and early intervention services to be beneficial. When deemed appropriate, PTR referred clients to our in-house pro-bono psychiatrists for medication evaluations and management and provided internal referrals for mental health treatment with our staff clinicians and clinical interns. During this fiscal year, we did not encounter any clients who required a referral for inpatient or residential care or to the Emergency Room for psychiatric evaluation or hospitalization.

3. Number of individuals who were successfully referred and linked (i.e. client has been seen at least once in person by a treatment provider):
   a. To an ACBH mental health treatment program: 0
   b. To a non-ACBH-funded mental health treatment program: 8

4. Average duration in weeks of signs of untreated mental illness (per client self-report) *(write "n/a" or "unknown" when applicable):* unknown

5. Average time in weeks between when a paper referral was given to individual by your program and the individual's first in person appointment with a mental health treatment provider *(write "n/a" or "unknown" when applicable)*: 1-3 weeks

   Due to our referrals to mental health treatment being internal referrals—either to our in-house psychiatrist or PTR's mental health clinicians—the average time between the referral being made and a client's first appointment is approximately 1-3 weeks.

TIMELY ACCESS (TO OTHER PEI-FUNDED PROGRAMS)

1. Number of separate paper referrals to another ACBH **PEI-funded** program. (You can find the PEI funded programs here. This can be a provider's internal or external ACBH PEI-funded program) *(write "n/a" or "unknown" when applicable)*: n/a

2. Number of individuals followed through on referral & engaged in an ACBH PEI-funded program *(write "n/a" or "unknown" when applicable)*: n/a

3. Average time in weeks between when a paper referral was given to individual by your program and the individual's first in person appointment with the ACBH PEI-funded provider *(write "n/a" or "unknown" when applicable)*: n/a

Prevention PEI Data Report FY 18/19

MHSA Program Number: PEI 14
Program Name: The Family Education and Resource Center (FERC)

The Family Education and Resource Center (FERC) is an innovative peer-to-peer program that provides education, advocacy, resources, support and hope to family caregivers of a loved one living with a mental health challenge. FERC is operated by the Mental Health Association of Alameda County (MHAAC).

General Information & Total Numbers Served

Total Numbers Served through PEI MHSA		
Number of unduplicated individuals your program serves who are **at-risk** of developing a mental health problem or serious mental illness (SMI)	**A**	
Number of unduplicated individuals your program serves who show **early signs** of forming a more severe mental illness	**B**	
Number of unduplicated individual family members served indirectly by your program: **AT FERC, WE DIRECTLY SERVE FAMILY CAREGIVERS**	**C**	2,948
Grand TOTAL of unduplicated individuals served in the Quarter that you are reporting about. [This number (D) should = A+B+C.]	**D**	2,948

Demographics

Age Group (Unduplicated)	
Children/Youth (0-15)	
Transition Age Youth (16-25)	3%
Adult (26-59)	75%
Older Adult (60+)	15%
Unknown/ Declined to Answer	7%

Race (Please mark only one choice) *If Hispanic or Latino, choose "Another race not listed."*	
American Indian or Alaska Native	
Asian	2%
Black or African American	30%
Native Hawaiian or other Pacific Islander	
White	45%
More than one race	5%
Another race not listed	15%
Unknown/ Declined to Answer	3%

Sexual Orientation (Please mark only one choice)	
Gay or Lesbian	15%
Heterosexual or Straight	49%
Bisexual	
Questioning or unsure of sexual orientation	1%
Queer	
Another sexual orientation not listed	
Unknown/Decline to Answer	35%

Ethnicity /Cultural Heritage (Please mark only once choice)	
If Hispanic or Latino, please specify:	
Caribbean	
Central American	
Mexican/Mexican--American/Chicano	10%
Puerto Rican	
South American	
Another Hispanic/Latino ethnicity not listed	5%
Unknown/Declined to Answer	
If Non-Hispanic or Non-Latino, please specify:	
African	1%
African American	25%
Asian Indian/South Asian	3%
Cambodian	
Chinese	1%
Eastern European	2%
European	30%
Filipino	
Japanese	
Korean	2%
Middle Eastern	3%
Vietnamese	
Other Non-Hispanic or Non-Latino ethnicity not listed	
More than one ethnicity	15%
Unknown /Declined to Answer	3%

Primary Language (Please mark only one choice)	
English	80%
Spanish	11%
Farsi	5%
Cantonese	1%
Mandarin	1%
Other Chinese Dialects	
Vietnamese	
Korean	2%
Tagalog	
Other Filipino Dialect	
Japanese	
Laotian	
Cambodian	
Mien	
Hmong	
Samoan	
Thai	
Russian	
Polish	
German	
Italian	
Turkish	
Hebrew	
French	
Portuguese	
Armenian	
Arabic	
Sign ASL	
Other primary language not listed	
Unknown/ Decline to Answer	

Gender Identity (Please mark both parts A & B)	
A) Assigned sex at birth: (Please mark only one choice)	
Male	30%
Female	65%
Other sex not listed (e.g. Intersex)	
Unknown/Decline to Answer	5%
B) Current Gender Identity: (Please mark only one choice)	
Male	29%
Female	65%
Transgender	1%
Genderqueer	
Questioning or Unsure of Gender Identity	
Another Gender Identity not listed	
Unknown/Decline to Answer	5%

Disability Status (Please mark all that apply)	
None	
Yes. If yes, please specify (choose from list below):	
Difficulty Seeing	X
Difficulty hearing, or having speech understood	X
Mental Domain	X
Physical/Mobility Domain	X
Chronic Health Condition	X
Another disability not listed	
Unknown/Decline to Answer	

Veteran Status (Please mark only one choice)	
Yes	15%
No	75%
Unknown/Decline to Answer	10%

REQUIRED STRATEGY: INCREASE ACCESS AND LINKAGE TO MENTAL HEALTH TREATMENT

a. Number of individuals with serious mental illness (SMI) who received a paper referral (i.e. referrals via phone do not apply) from your program to an ACBHCS mental health treatment program: Difficult to answer this question; we are not a direct referral program. But we have printed out program overviews and summaries for clients to understand more about a particular program. Most of our referrals are done via phone – ACCESS.

b. List type(s) of mental health treatment programs the individual was referred to: We have helped clients get appointments through ACCESS. They were referred to: Oakland Community Supports, BACS, Telecare, IHOT, ABODE, STARS, Bonita House and La Familia.

c. Number of individuals who were successfully referred and linked to an ACBHCS mental health treatment program (i.e. client has been seen at least once in person by a treatment provider): <100

d. Average duration in weeks of signs of untreated mental illness (per client self-report): Average 24-48 weeks

e. Average time in weeks between when a paper referral was given to individual by your program and the individual's first in person appointment with a mental health treatment provider: We do not do direct referrals.

f. Any additional information to report on? (optional): Click here to enter text.

REQUIRED STRATEGY: IMPROVE TIMELY ACCESS TO MENTAL HEALTH SERVICES FOR UNDERSERVED POPULATIONS

a. Who is/are the underserved target population/s your program is serving (e.g. TAY, Southeast Asian, etc.)? TAY, Middle Eastern, African American TAY

b. Number of separate paper referrals to an ACBHCS PEI-funded program. (This can be a provider's internal ACBHCS PEI-funded prevention or early intervention program OR an external PEI-funded ACBHCS prevention or early intervention program): 90% of our client's loved ones are given referrals to ACBHCS and/or CBOs within Alameda County.

c. Number of individuals followed through on referral & engaged in an ACBHCS PEI-funded program: More than 50% of our clients have followed through on our referrals and had their loved one attend a meeting or meet with a provider from the other program. The challenges we experience is when they do not "connect" with the other provider(s) and do not want to participate or be a part of their program. The client's loved ones report, "not wanting to tell their story again; having their case manager leave (turn-over rates are high)."

d. Average time in weeks between when a paper referral was given to individual by your program and the individual's first in person appointment with the ACBHCS PEI-funded provider. 2w-4w for ACCESS; no direct paper referrals from FERC.

e. Describe ways your program encouraged access to services and follow-through on the above referrals: At FERC, we do our best to practice warm hand-offs. We connect with the provider from the other programs and request a warm hand-off meeting or ask them to come to one of our family meetings. We offer to attend their first meeting with other providers to ensure linkage.

f. Any additional information to report on (optional): Click here to enter text.

OUTREACH. THIS SECTION IS *REQUIRED ONLY* FOR OUTREACH PROGRAMS. OTHERWISE, IT IS OPTIONAL

Number of potential responders: Click here to enter text.

List type of setting(s) in which the potential responders received outreach and the type(s) of potential responders engaged in each setting:

Type of Setting(s) (ex: school, place of worship, clinic)	**Type(s) of Potential Responders** (ex: principals, teachers, parents, nurses)
Muslim Mosque, Tri-Valley	Community members
Oakland Police Dept.	New academy recruits / future law enforcement officers
Oakland Police Dept. CIT	Crisis Intervention Training: law enforcement; Sgts, Housing
Fremont Unified School	Principal, teachers, parents, social workers, counselors;
Tri-City Youth	Counselors, parents, therapists
Hopkins Junior High School	Parents, teachers, principal
Behavioral Health Court	Judges, DA, case managers
Veterans Affairs	Social Workers
Spectrum, Hayward	Counselors, parents, teacher(s)
Union City Family Center	Parents, teachers, TAY, counselors
CSUEB	Graduate students in nursing; professors, nurse
SFSU	Graduate students, professor(s)
Rotary Club, Berkeley	Community members, business professionals
Downtown Livermore	Community members, parents, local business owners
San Jose HS, Fremont	Counselors, parents, teachers, principal
Irvington HS, Fremont	Parents, teachers, principal
Oakland Housing Authority	Providers, community members, housing reps
UHURU House Health Fair	Community members, health providers,
Crisis Support Services Walk	Community members, health providers, locals
We Move for Health 10x10	Community members, health providers, locals
Senior Expo Health Fair	Community members, health providers, locals
4 C's Annual Kid's Health Fair	Community members, health providers, locals
27th Annual Livermore Fair	Community members, health providers, locals
Juneteenth Annual Fair	Community members, health providers, locals
Allen Temple Church Health Fair	Community members, faith based leaders, locals
Paradise Baptist Church Health Fair	Community members, faith based leaders, locals
Out of the Darkness Suicide Prevention Walk	Community members, health providers, locals
Livermore Farmers Market	Community members, health providers, locals

NARRATIVE

a. Choose two of the above principles and describe how your program upholds or achieves those principles. Please speak to each principle separately and specifically describe how your program activities align with that corresponding principle.

Principle #1: Community Collaboration: How does your program align with this principle? At FERC, we connect our clients and their loved ones through warm hand-off meetings. We offer to attend a first meeting or we arrange it within our own offices so our clients and their loved ones feel more comfortable. In addition to warm hand-offs, we work with other agencies to provide the level of support to the family caregivers that they themselves may not have capacity for. As these providers work with the consumers, we work with their support persons, family and caregivers. We connect families to other PEI programs, ACBH, and CBOs. We support clients through various stages of where they are at with their loved one. Often times, they are calling FERC because it is the first time their loved one is experiencing a mental health challenge or crisis. This is very new and terrifying for families who are experiencing this for the first time and do not understand the confidentiality laws and HIPAA. It can be the most frustrating experience trying to help their loved one and not having someone properly educate them in a patient manner on these patient privacy laws. Many times, providers assume that families and caregivers should know HIPAA and they can be very rude and disrespectful. We often have to start from the beginning and educate families on patient privacy, confidentiality and what a Release of Information is in addition to the crisis they are enduring.

Principle #2: Client, Consumer, and Family Involvement . How does your program align with this principle? FERC is a family caregiver centered program. We work with everyone in the family, including the consumer – AKA loved ones. We believe in strengthening the family unit by including all members to have an equal voice and work towards shared goals. W provide resources and linkages to referrals for the loved ones while providing education and support to their family caregivers.

b. Please tell us about the following…

i. Implementation Challenges: It is still difficult to link clients to treatment services since we cannot do direct internal referrals. Sometimes providers do not return our calls and it is frustrating when we simply want to know general information – not private information regarding the clients, but they prevent us due to HIPAA and Confidentiality. They use this to shield communication and this ONLY hurts our consumer clients. Another challenge is when providers from the other agencies do not follow through with what they are supposed to do with / for the client. Often times, Family Advocates at FERC feel like we are case managers who are continuously trying to get a hold of their case manager from another program.

ii. Successes: When providers see the benefits of working with a Family Advocate from FERC and then they start to refer their colleagues to connect with a FA; when we receive referrals from law enforcement who have given our brochure to families during a 5150 call; when consumers tell us that their relationship with their family has improved since their involvement with FERC; helping families understand mental illness, that their loved one is not doing “anything wrong” or “on purpose.”

iii. Lessons Learned: Click here to enter text.

iv. Relevant Examples of Success/Impact (e.g. a client success story) Reminder: Please do not use real client names: Family success story: Family was connected to FERC b/c their son was admitted to John George; he has a diagnosis of schizophrenia, anxiety, PTSD, depression and substance use. FERC was able to educate the parents on mental illness, print fact sheets in their native language (Korean), regularly meet with the parents and talk about communication between them and their son, FERC met with their son, advocated for case management, got into Level 1 care, but eventually the son got frustrated with the service team b/c of their high turn-over rate in case management; but still continued to work with FERC, got clean and sober, eventually was accepted into the ACBHCS – ACAPS program via letter recommendation from FERC, client completed an accelerated peer certification program, has completed WRAP training, and FERC helped with supporting client while working at Sally’s Place (La Familia program)– while still supporting the parent’s needs. Consumer client is thriving at work and feeling like he is giving back to the mental health community. Parents cannot be happier; they get emotional talking about the past, calling it a nightmare. They cannot believe their son has a real job, they are extremely grateful for FERC. ***If you need a more detailed summary, I will be happy to provide one***

ADDITIONAL INFORMATION

a. Please describe, in 1-2 sentences, your effort to collect feedback from program participants (method used). Please include the timeframes of when you survey clients. At FERC, we ask clients to complete a survey after we have met with them on average 2-3xs. We generally do not ask them to complete a survey after our first meeting, it wouldn't make sense. We provide an online option as well as: self-addressed and post marked back to FERC, or we ask them to fill it out and drop it inside a locked box located at each of our four office sites.

b. Describe the tool (i.e. MHSIP or another survey) used to collect data. We have a programmer who is currently working on this reporting aspect. Soon we will be able to enter in each survey and it will generate a report summary including comments.

c. Summarize the results if any. Majority of our client's satisfaction have reported "Highly Satisfied" and that they have experienced an improvement in their relationship with their loved one.

d. What was learned from the participant feedback (**1-2 key points**)?The challenges are with the "system" more than anything else. The barriers to receiving services are harder than the interactions with their loved ones. Another challenging area: resources. The LACK of available and appropriate resources. Not enough beds; early discharge; housing; unsafe shelters.

e. Describe how the findings were reviewed by staff. It is optional for clients to write their name and the name of their Family Advocate. However, 98% of the clients mention their FA name b/c they are pleased with their services. So if they write an actual FA name, then a copy is given to the FA so they know how their work has impacted their client. If there is no name and something of concern in the comments and feedback, I have addressed it in a staff meeting for all to keep in mind and for us to discuss as a team.

f. What programmatic change(s) were or will be adopted as a result of the findings? When will changes be made and how will the changes impact programming? N/A

g. What issues or challenges with the Evaluation Plan are you having? What technical assistance do you need? The challenge is data entry for the reports. I do not have someone who has the time to input all of the data.

Prevention Data Report FY 18/19

MHSA Program Number: PEI 20A
Program Name: Culturally Responsive PEI Programs for the African American Community- Beats, Rhymes and Life (BRL)

BRL cultivates dynamic, culturally responsive services that inspire youth to recognize their own capacity for healing and expression, through community engagement and the therapeutic power of Hip Hop.

General Information & Total Numbers Served

Total Numbers Served through PEI MHSA		
Number of unduplicated individuals your program serves who are **at-risk** of developing a mental health problem or serious mental illness (SMI)	**A**	4
Number of unduplicated individuals your program serves who show **early signs** of forming a more severe mental illness	**B**	0
Number of unduplicated individual family members served indirectly by your program:	**C**	56
Grand TOTAL of unduplicated individuals served in the Quarter that you are reporting about. [This number (D) should = A+B+C.]	**D**	60

Demographics

Age Group (Unduplicated)	
Children/Youth (0-15)	
Transition Age Youth (16-25)	60
Adult (26-59)	
Older Adult (60+)	
Unknown/ Declined to Answer	

Race (Please mark only one choice) *If Hispanic or Latino, choose "Another race not listed."*	
American Indian or Alaska Native	
Asian	
Black or African American	48
Native Hawaiian or other Pacific Islander	
White	4
More than one race	
Another race not listed	12
Unknown/ Declined to Answer	

Ethnicity /Cultural Heritage (Please mark only once choice)	
If Hispanic or Latino, please specify:	
Caribbean	
Central American	
Mexican/Mexican--American/Chicano	4
Puerto Rican	4
South American	
Another Hispanic/Latino ethnicity not listed	
Unknown/Declined to Answer	
If Non-Hispanic or Non-Latino, please specify:	
African	
African American	48
Asian Indian/South Asian	
Cambodian	
Chinese	
Eastern European	
European	4
Filipino	
Japanese	
Korean	
Middle Eastern	
Vietnamese	
Other Non-Hispanic or Non-Latino ethnicity not listed	
More than one ethnicity	
Unknown /Declined to Answer	

Sexual Orientation (Please mark only one choice)	
Gay or Lesbian	
Heterosexual or Straight	
Bisexual	
Questioning or unsure of sexual orientation	
Queer	4
Another sexual orientation not listed	
Unknown/Decline to Answer	

Primary Language (Please mark only one choice)	
English	48
Spanish	12
Farsi	
Cantonese	
Mandarin	
Other Chinese Dialects	
Vietnamese	
Korean	
Tagalog	
Other Filipino Dialect	
Japanese	
Laotian	
Cambodian	
Mien	
Hmong	
Samoan	
Thai	
Russian	
Polish	
German	
Italian	
Turkish	
Hebrew	
French	
Portuguese	
Armenian	
Arabic	
Sign ASL	
Other primary language not listed	
Unknown/ Decline to Answer	

Gender Identity (Please mark both parts A & B)	
A) Assigned sex at birth: (Please mark only one choice)	
Male	32
Female	28
Other sex not listed (e.g. Intersex)	
Unknown/Decline to Answer	
B) Current Gender Identity: (Please mark only one choice)	
Male	
Female	
Transgender	
Genderqueer	4
Questioning or Unsure of Gender Identity	
Another Gender Identity not listed	
Unknown/Decline to Answer	

Disability Status (Please mark all that apply)	
None	60
Yes. If yes, please specify (choose from list below):	
Difficulty Seeing	
Difficulty hearing, or having speech understood	
Mental Domain	
Physical/Mobility Domain	
Chronic Health Condition	
Another disability not listed	
Unknown/Decline to Answer	

Veteran Status (Please mark only one choice)	
Yes	
No	60
Unknown/Decline to Answer	

REQUIRED STRATEGY: IMPROVE TIMELY ACCESS TO MENTAL HEALTH SERVICES FOR UNDERSERVED POPULATIONS

a. Who is/are the underserved target population/s your program is serving (e.g. TAY, Southeast Asian, etc.)? African American Males

b. Number of separate paper referrals to an ACBHCS PEI-funded program. (This can be a provider's internal ACBHCS PEI-funded prevention or early intervention program OR an external PEI-funded ACBHCS prevention or early intervention program): none

c. Number of individuals followed through on referral & engaged in an ACBHCS PEI-funded program: n/a

d. Average time in weeks between when a paper referral was given to individual by your program and the individual's first in person appointment with the ACBHCS PEI-funded provider. Most of our clients go through an extensive interview/intake process. Most clients showed no sign of mental illness or had issues that were managed by our team which included a Case Manager and Social Worker

e. Describe ways your program encouraged access to services and follow-through on the above referrals: Our Outreach team travels to outreach events within Alameda to provide workshops, performances, and Mental Health panels to share best practices and available resources to families, educators and other mental health agencies.

f. Any additional information to report on (optional): none

NARRATIVE

a. Choose two of the above principles and describe how your program upholds or achieves those principles. Please speak to each principle separately and specifically describe how your program activities align with that corresponding principle.

Principle #1: Choose an item. How does your program align with Cultural Competence? Beats Rhymes & Life exemplifies a cultural competent agency. Our target population is African American; and a lot of African American youth listen to popular music. We centered our agency at the intersection of Hip Hop and therapy to meet the youth where they're most active. Hip-Hop aligns with our therapeutic interventions which include Self Psychology, Group work/Relational therapy, & Narrative Therapy. Hip-Hop was born in response to poverty in neighborhoods that were historically underserved as a medium of expression and engagement for community members. Our model was designed with a trauma informed relational psychodynamic social justice, youth development framework. Beats Rhymes & Life, since its inception has built its Mission, Vision, Values, and Program design to engage youth. Our mission is to cultivate culturally responsive services through community engagement and the therapeutic power of Hip-Hop that inspires youth to recognize their own capacity for healing and self-expression. BRL's vision is to utilize Hip-Hop Therapy for individual, community, and systemic change. Our Academy (peer-mentor development) model included 1:1 meetings with our social worker, and case-manager; in addition to cross training in hip hop artistry/Group work theory, resource class in which we bring in outside resources (focusing on ACBH contractors) to build with our youth based on needs reported to our case manager and Leadership class in which we use personal challenges to validate each other's experiences as well as collaborate on breaking toxic cycles.

Principle #2: Choose an item. How does your program align with Wellness and Recovery? We have a two-part interview/intake process in choosing candidates for entering BRL's peer mentorship workforce development academy. Interview process can be anywhere from 45mins to an hour and a half. We are very transparent about our agency's mission, theory of change, and program model. We let them know that it involves therapy and case management. We ask what their associations and experience are with therapists are and what works and/or doesn't work for them in those experiences. We share our model, ask for their feedback and confirm it's something they can work with.

Critical feedback from youth in regards to systems youth encounter is that they don't reflect all relevant needs of youth, they're met with demands and intrusive questions with little to no collaboration, and there is little to no engagement and genuine attempts to build connection with them. We work earnestly to develop curriculum that is relevant to their needs and solicit feedback to what could help more. We do this until they realize that their feedback is leading the learning experiences they are having. In our clinical sessions and our case management 1:1's youth set all the goals. In the last six months of the program we enter into envisioning where they want to be even if they're not hired by our agency at that time. So if the goal is to have a better relationship with a family member, to find an affordable place to stay, to enter or re-enter school, have more friends they can trust, resolve a child custody dispute, or get their driver's license, we support them in achieving those goals.

b. Please tell us about the following…

i. Implementation Challenges: That by the time the two year program is almost over we are just gaining

participants trust and they're just beginning to scratch the surface of their cycles of trauma.

ii. Successes: We are hiring three members of the 15-member cohort to hold part time jobs with our organization and entering the next two year training in working in this industry.

iii. Lessons Learned: Introduce them to referral sources earlier and get those services to be part of our community in professional and personal ways earlier; to prevent them to being referred to a stranger later.

iv. Relevant Examples of Success/Impact (e.g. a client success story) Reminder: Please do not use real client names: Female enters the final year of the program looking for support with housing, employment, and depression due to loss of a family matriarch. TAY entered with aspiration of making music as it is both a validating experience to perform her original music and a therapeutic release. She got to collaborate on two albums with us and make her own solo album. She performed at two of our showcases to much success and applause. Our case manager helped her strategize and prepped her in gaining a housing and full time employment as a security guard at Google. Her clinician helped her unravel a lot of her prior family trauma and false narratives of herself. She also started a meditation practice which continues to aid and ease negative thoughts and anxiety.

Optional: Do you give permission to BHCS to use this success story in a public forum (i.e. MHSA website, BHCS meeting)? ☐Yes ☐No

Additional Information

Please include the number of clients and/or contacts you estimate to serve in:

FY 19/20: 20/45
FY 20/21: 20/45

Please tell us about any changes you intend to make to your program over the next two fiscal years and explain your rationale for making these changes: We plan to transition the Academy Workforce Preparation model to a more prevention model with the goal of reaching 80 unduplicated youth over the next two years.

Prevention Data Report FY 18/19

MHSA Program Number: PEI 20D
Program Name: Culturally Responsive PEI Programs for the African American Community-Restorative Justice for Oakland Youth (RJOY)

Restorative Justice for Oakland Youth (RJOY) that provides empowerment and healing circles incorporating Afrocentric and indigenous restorative justice-based practices for adults and youth in community and school settings.

General Information & Total Numbers Served

Total Numbers Served through PEI MHSA		Total, 3rd Quarter	Total, 3rd and 4th Quarter	Survey Results
Number of unduplicated individuals your program serves who are **at-risk** [1]of developing a mental health problem or serious mental illness (SMI)[2]	A	344	344+240=584	49
Number of unduplicated individuals your program serves who show **early signs** of forming a more severe mental illness	B	0	0	0
Number of unduplicated individual family members[3] served indirectly by your program:	C	0	0	0
Grand TOTAL of unduplicated individuals served in the Quarter that you are reporting about. [This number (D) should = A+B+C.]	D	344	344+240=584	49

Demographics

Age Group (Unduplicated)	3rd Quarter	Total 3rd and 4th Quarter	Survey Results
Children/Youth (0--15)	88	88 + 29=117	6 (12.2%)
Transition Age Youth (16--25)	65	65 +112=177	23 (46.9%)
Adult (26--59)	184	184+34= 218	7 (14.2%)
Older Adult (60+)	7	7+19= 26	4 (8.1%)
Unknown/ Declined to Answer	0	0+46 = 46	9 (18.3%)
Total	344	344+240=584	49

Primary Language (Please mark only one choice)	3rd Quarter	Total, 3rd and 4th Quarter	Survey Results
English	294	294+186= 440	38 (77.5%)
Spanish	50	50+34= 84	7 (14.2%)
Farsi	0	0+5=5	1 (2%)
Cantonese	0	0	0
Mandarin	0	0	0
Other Chinese Dialects	0	0	0
Vietnamese	0	0	0
Korean	0	0	0
Tagalog	0	0	0
Other Filipino Dialect	0	0	0
Japanese	0	0	0
Laotian	0	0+5=5	1 (2%)
Cambodian	0	0	0
Mien	0	0	0
Hmong	0	0	0
Samoan	0	0	0
Thai	0	0	0
Russian	0	0	0
Polish	0	0	0
German	0	0	0
Italian	0	0+5=5	1 (2%)
Turkish	0	0	0
Hebrew	0	0	0
French	0	0	0
Portuguese	0	0	0
Armenian	0	0	0
Arabic	0	0+5=5	1 (2%)
Sign ASL	0	0	0

Other primary language not listed	0	0+5=5	1 (2%)
Total:	344	344+240=584	49

Gender Identity (Please mark both parts A & B)	3rd Quarter	Total, 3rd and 4th Quarter	Survey Results
A) Assigned sex at birth: (Please mark only one choice)			
Male	201	201+152=353	30 (63%)
Female	143	143+74=217	15 (31%)
Other sex not listed (e.g. Intersex)	0	0	0
Unknown/Decline to Answer	0	0+14= 14	3 (6%)
B) Current Gender Identity: (Please mark only one choice)			
Male	199	199+147=346	30 (61.2%)
Female	141	141+73= 214	15 (31%)
Transgender	0	0	0
Genderqueer	4	4+3=7	1 (1.1%)
Questioning/Unsure of Gender Identity	0	0	0
Unknown/Declined to answer	0	0+14=14	3 (6%)
Total	344	344+240=584	49

Sexual Orientation (Please mark only one choice)	3rd Quarter	Total, 3rd and 4th Quarter	Survey Results
Gay or Lesbian	8	8+10= 18	2 (4%)
Heterosexual or Straight	0	0+170=170	35 (71%)
Bisexual	0	0+10=10	2 (4%)
Questioning or unsure of sexual orientation	0	0	0
Queer	0	0+5= 5	1 (2%)
Another sexual orientation not listed	0	0+10= 10	2 (4%)

Unknown/Decline to Answer	336	0+34= 34	7 (14%)
Total	344	344+240=584	49

Disability Status (Please mark all that apply)	3rd Quarter	Total, 3rd and 4th Quarter	Survey Results
None	0	0+196=196	40 (81.6%)
Yes. If yes, please specify (choose from list below):	0	0+44=44	9 (18.3%)
Difficulty Seeing	0	0+4=4	1 (2%)
Difficulty hearing, or having speech understood	0	0	0
Mental Domain	0	0+20=20	4 (8.2%)
Physical/Mobility Domain	0	0	0
Chronic Health Condition	0	0	0
Another disability not listed (LD):	0	0+20=20	4 (8.2%)
Unknown/Decline to Answer	344	344+0=344	0
Total	344	344+240=584	49

Veteran Status (Please mark only one choice)	3rd Quarter	Total,3rd and 4th Quarter	Survey Results
Yes	0	0+34=34	7 (14.2%)
No	0	0+191= 191	39 (79.5%)
Unknown/Decline to Answer	344	0+15=15	3 (6.1%)
Total	344	344+240=584	49

REQUIRED STRATEGY: INCREASE ACCESS AND LINKAGE TO MENTAL HEALTH TREATMENT

a. Number of individuals with serious mental illness (SMI) who received a paper referral (i.e. referrals via phone do not apply) from your program to an ACBHCS mental health treatment program: During the period between January 1 and July 31, 2019 ("Quarters 3 and 4) 9 individuals received a paper referral to a mental health treatment program.

b. List type(s) of mental health treatment programs the individual was referred to: Conscious Voices; Serenity House; Genesis; ROOTS

c. Number of individuals who were successfully referred and linked to an ACBHCS mental health treatment program (i.e. client has been seen at least once in person by a treatment provider): 9

d. Average duration in weeks of signs of untreated mental illness (per client self-report) 1 week

e. Average time in weeks between when a paper referral was given to individual by your program and the individual's first in person appointment with a mental health treatment provider: 1-2 weeks

f. Any additional information to report on? (Optional): We are in the process of identifying and expanding our list of ACBHCS mental health treatment programs and services, making direct contact with other service providers that provide different and more intensive treatment services for community members with more complex mental health challenges. We are also reevaluating and revising our referral process, based on our experience in the first 6 months of the Project.

Required Strategy: Improve Timely Access to Mental Health Services for Underserved Populations

a. Who is/are the underserved target population/s your program is serving (e.g. TAY, Southeast Asian, etc.)? RJOY is serving African Americans in Alameda County who are in need of access to culturally sensitive and responsive mental health healing services, including Black Men, Women & Girls, elders, young people (11-17 years), young men and women in Juvenile Hall and Camp Sweeney (15-21 years), Community Mental Health Workers, and queer people of color.

b. Number of separate paper referrals to an ACBHCS PEI-funded program. (This can be a provider's internal ACBHCS PEI-funded prevention or early intervention program OR an external PEI-funded ACBHCS prevention or early intervention program): 459 individuals received referrals to Africentric Healing Circles during the first two quarters of RJOY's AA Healing Circles Project.

c. Number of individuals followed through on referral & engaged in an ACBHCS PEI-funded program: 484 unduplicated individuals (participants) and an additional 100 relatives, family members, parents, teachers, and community members

d. Average time in weeks between when a paper referral was given to individual by your program and the individual's first in person appointment with the ACBHCS PEI-funded provider. One week

e. Describe ways your program encouraged access to services and follow-through on the above referrals: RJOY engages individuals in the Alameda County community and youth in juvenile detention through an intensive process of outreach, engagement and follow-through. We have ongoing contact with our Circle participants, often doing follow up and outreach between Healing Circles. We encourage our Healing Circle participants to participate in other RJOY activities and events

f. Any additional information to report on (optional): RJOY exceeded the goals and objectives identified in our grant proposal by reaching 584 unduplicated individuals through 12 Africentric Healing Circles (271 participants), 2 additional Racial Healing Circles (188), 1 Community Celebration (35), one Community Healing event (60), and two RJ Trainings (30). We held 141 separate Africentric Community Healing Circles, which represents 1690 "duplicated" participants. We are on track to more than double our original projection of 450 unduplicated participants. Three of our Circles have already completed 21 individual Circles in the first two quarters of the grant.

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

RJOY Africentric Healing Circles Project 2019 Annual Report

Type of Circle/Event	# of Circles/ Events	Participants (unduplicated)	Participants (Duplicated)	Average number of Participants
Black Male Circle	21	50	183	8.7
Sisters Rising	12	27	77	6.4
QPOC	7	16	30	4.2
Peer Circle (Rockridge)	15	35	48	12
Peer Circle (Cesar Chavez)	15	37	85	5.6
Camp Sweeney	6	7	33	5.5
Community MH Workers	12	9	61	5.1
Elders	7	12	23	3.2
Uplift (Juvenile Girls)	7	18	37	5.2
Juvenile Hall (Boys) (#1 Circle)	21	21	252	12
Juvenile Hall (Boys) (#2 Circle)	21	21	252	12
Black Men/Black Women	3	12	20	6.6
SPES Racial Healing Circles	12	180	320	180
BHCS AA Healing Circle	1	8	8	8
AA Healing Trainings	2	15	30	15
AA Healing Celebration	1	35	35	35
AA Community Healing Event	1	60	60	60
TOTAL	164	584	1,815	

Africentric Healing Circles:

1. Black Male Circle: BMC is a space for Men of Color ages 15+ to heal, share, community build, navigate conflict, celebrate, collaborate, and engage in dialogue centering issues relative to the masculine POC experience. Circles are held in the RJOY office every Thursday 6pm-8pm.
2. Sisters Rising Circle is an intergenerational space for women and girls to engage in healing, the arts, movement, dialogue and expression, centering issues affecting POC femmes, especially voices across the African Diaspora.
3. QPOC Circle: Queer People of Color Circles (QPOC) is an intentional space centering queer bay area people of color to meet, community build, network, support, learn, share and heal utilizing the practice of Restorative Justice. This weekly space is made for folks of color who identify as LGBTQIA+ and allies for the sake of deeper and more nuanced conversation as it applies to our beloved community.
4. #1 Peer Circle (Rockridge Library) Peer Circles for youth is a space for ages 11+ held at the Oakland Public Library's Rockridge and Cesar E. Branches. Here, youth learn about restorative justice in circle where we use tools like Hip Hop, development of leadership skills, deep sharing, awareness, emotional intelligence, interactive activities, and a whole lot of joy and laughter. The Rockridge Library Peer Circle met for a period of 15 weeks, and, due to summer recess, the Rockridge Peer Circle is currently on hiatus, but will resume once the school year starts.
5. #2 Peer Circle (Cesar Chavez Library) (see above) At Cesar E. Branches we hold Circles currently every 1st & 3rd Friday 4pm-5pm, and are continuing to hold these Circles during the summer months.
6. #1 Juvenile Hall (Boys Circle): RJOY conducts healing Circles on a weekly basis at the Juvenile Hall (2 Circles for Boys and one for Girls) in which young people in detention learn about and practice restorative justice, making deep connections with the circle keepers and developing strong and effective strategies to deal with past trauma, accountability, and individual, family and community healing
7. #2 Juvenile Hall Boys Circle (see above)

8. Juvenile Hall (Girls Circle), now called Uplift, is a Circle for young women in Alameda County Juvenile Hall which focuses on healing and transformation for girls dealing with the trauma of incarceration, as well as life issues affecting young women in custody.
9. Camp Sweeney (Boys Circle) is a weekly circle for young men in detention at the Juvenile detention camp, addressing a variety of important life issues and giving the participants a chance to find healing and transformation. RJOY conducted 6 Healing Circles with Camp Sweeney youth, and Circles are no on hold while RJOY re-negotiates our programs with correctional staff.
10. Community Mental Health Worker Circles with African American women (many formerly incarcerated and in recovery) working in community mental health, with staff from Conscious Voices and RJOY.
11. Elder's Circle: Elder's Circle is a weekly gathering for community members to share wisdom in a restorative space. Elder's Circles are an embodied experience that can feature anything from deep breathing and music to movement and the infusion of African Spirituality through ritual.
12. The Black Men and Women's Circle is an outgrowth of the Black Male Circle, and came together specifically to address the complex and important relationships between Black Men and Women, and areas of deep healing and communication.

Racial Justice Community Healing Circles:

1. SPES Racial Healing Circles: RJOY conducted a series of Healing Circles for 180 8th grade students, teachers, administrators and parents at St. Paul's Episcopal School in Oakland, California after a racially harmful incident. Twelve Circles were conducted in total, 6 with all 8th graders and 6 with parents and teachers.
2. BHCS African American Women's Circle: A one-time Circle with 8 participants

Africentric Healing Circles Curriculum Development

RJOY is developing individual curricula for each of the Africentric Healing Circles.

Africentric Healing Circles Celebrations:

First Community Celebration: The first Africentric Healing Circles Celebration took place on April 11, 2019 at the Metropolitan Golf Links Center. We welcomed 35 participants who joined us for a delicious dinner and a wonderful presentation by Luisah Teish, a storyteller-writer, artist-activist and spiritual guidance counselor. She is an initiated elder (Iyanifa) in the Ifa/Orisha tradition of the West African Diaspora. Luisah led the participants in ritual, celebration, dancing and song. The second Africentric Healing Circles Community Celebration is scheduled for September 26, 2019, and will include participants from the Africentric Healing Circles as well as many community members and restorative justice practitioners. We also plan to have a 3rd Africentric Community Celebration in December, 2019.

RJ Empowerment/ Healing Trainings:

RJOY conducted one Tier One and one Tier Two Training during the first six months of the grant period. The Tier One training involved 15 community members, and the Tier Two training involved 15 community members. In addition, our community partners, Conscious Voices and Hip Hop Heals, conducted two trainings for RJOY staff, volunteers and interns. We are planning an upcoming training opportunity: free Community Restorative Justice Healing Trainings August 10 and 17, 2019.

OUTREACH. THIS SECTION IS *REQUIRED ONLY* FOR OUTREACH PROGRAMS. OTHERWISE, IT IS OPTIONAL

Number of potential responders: Click here to enter text.

List type of setting(s) in which the potential responders received outreach and the type(s) of potential responders engaged in each setting:

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

Type of Setting(s) (ex: school, place of worship, clinic)	**Type(s) of Potential Responders** (ex: principals, teachers, parents, nurses)
Genesis Project and Recovery program (non-profit)	Non-profit community staff and participants of the program
St. Columba Church, Oakland (place of worship)	Diverse community (racially and economically)
North Oakland Restorative Justice (non-profit)	Community members, including people who are formerly incarcerated, family members of people in prison, parents and students, elders and youth
Restorative Justice Council (non-profit)	Network of non-profit staff and volunteers from restorative and transformative justice programs; teachers, students, community members
RJ in Schools Learning Community (schools)	Teachers, administrators, parents, student leaders
National Association of Community and Restorative Justice Conference	Non-profit community and staff working in restorative justice, community healing and peace building

NARRATIVE

a. Choose two of the above principles and describe how your program upholds or achieves those principles. Please speak to each principle separately and specifically describe how your program activities align with that corresponding principle.

3rd Quarter:
Principle #1: Cultural Competence: How does your program align with this principle? RJOY is deeply committed to provide healing services to people in our community who have, historically, been underserved by traditional mental health and health services, particularly to African American community members and other community members of color. All our programs and services emphasize authentic and deep indigenous healing practices and values, and we continue to incorporate these values and customs in all of the work that we do. We believe that, by embracing and emphasizing indigenously-rooted restorative justice healing practices in our Africentric Healing Circles, we are providing an effective and essential pathway to mental health and healing for many of our community members who have felt disconnected and alienated from traditional mental health services.

Principle #2: Wellness and Recovery: How does your program align with this principle? RJOY emphasizes the importance of recovery, healing and resilience by engaging our participants in every aspect of the healing process. Participants meet in circle, sharing a deep process of accountability, shared values, radical honesty, and self-care. Circle participants receive support and also give support to fellow circle members, learning restorative justice values and practices that transform the ways in which they resolve conflict and challenges in their own lives, in their families and in the community at large. Through this intensive process, our participants move toward more positive and fulfilling lives, strengthening their relationships with their families, friends and loved ones, developing stronger coping mechanisms, dealing more effectively with stressors in their lives, and learning concrete tools for health and healing.

4th Quarter:
Principle #3: Community Collaboration: RJOY has extensive relationships with community members and non-profit organizations working to promote community healing and transformation through a variety of methods. Our Africentric Healing Circles Project has enabled us to expand our networks and collaborations even further.

We have recently been awarded a grant from Oakland Unite through their Community Healing strategy, and are excited about the prospect of doing more intentional collaboration with our four other community partners (UPM, CURYJ, ROOTS and BOSS.)

We work closely with Community Works, Restore Oakland, Impact Justice, the Ahimsa Project, and other community based non-profits doing community restorative justice. We work with an extensive network of teachers, administrators, students and parents through our RJ in Schools Project, and have been able to recruit additional participants for our Africentric Healing Circles through all of these collaborations.

Principle #4: Client, Consumer and Family Involvement: RJOY centers our work and our philosophy around the full involvement of, and agency of, African American community members in the process of healing and transformation. We believe that "hurt people hurt people, and healed people heal people." We involve family members and community advocates in our Healing Circle work with our young people at Juvenile Hall and Camp Sweeney, and feel that family support and involvement is critical for successful transition back into the community for our participants involved in the criminal legal system. Recently, through the leadership of one of our staff members who is formerly incarcerated, we have started developing a process of "Family Repair Beyond the Bars," where people who have served time in prison and jail come together with family members for intentional conversations and around healing relationships. We do not use the terms "client" and "consumer" and prefer the term "participant" because it implies a sense of agency and involvement in both individual and community healing for our African American community members.

b. Please tell us about the following…

i. **Implementation Challenges**: The work that we did in the first two quarters of the grant period has resulted in considerable growth and development of all of our Africentric Healing Circles. During the past six months, we have spent considerable effort in recruitment and outreach for all of the Circles. A few of the Circles presented challenges in the recruitment process (QPOC, Sisters Rising, Elders Circle) and we re-doubled our efforts in the second quarter of the grant to recruit and draw in participants for these Circles. We understand that for each of the Circles, the recruitment process must be consistent and intensive because we are dealing with a system of health and mental health care that has often failed our participants. Participants have rarely had therapeutic experiences that have been welcoming and culturally appropriate, and have often been further traumatized by these experiences rather than receiving the help and support that they need and deserve. From April 1 to July 31, 2019, we increased our total participant numbers to 359 unduplicated participants reached in a total of 12 Africentric Healing Circles, and 2 additional Racial Healing Circle processes.

ii. **Successes**: We have experienced many extraordinary successes in the first two quarters of the grant year. Overall, we served at total of 584 unduplicated individuals: 271 unduplicated participants in 12 Africentric Healing Circles and 188 unduplicated participants (through a school-based Community Healing Circles process that focuses on Racial and Community Healing and a one-time African American Women's Healing Circle) and 125 additional community members through our Africentric Healing Celebration, Community Healing event and RJ Trainings. Our Black Men's Circle continues to be our model Circle, with significant and enthusiastic participation from African American men who represent a range of experiences, ages and life challenges. The Black Men's Circle even seeded a new Circle for Black Men and Black Women who are engaging in deep dialogue with each other. Our Peer Circles for young people of color between the ages of 11-17 are done at two Oakland Libraries (Cesar Chavez and Rockridge Libraries), which has created a wonderful support structure for our young participants. The Rockridge Circle is currently on hiatus during the summer, but the Cesar Chavez Circle has continued throughout the summer. Our partnership with Conscious Voices is flourishing, and has led to a Circle for Community Mental Health Workers, primarily formerly incarcerated African American women learning to be community mental health workers. Our Circles in Juvenile Hall (2 for Boys, one for girls) remain strong, offering real opportunities for healing and transformation to some of our most vulnerable youth. Our Circle for Boys at Camp Sweeney is experiencing some challenges as we negotiate our ongoing relationship with correctional staff at that facility.

Finally, our QPOC and Sisters Rising Circles have developed strong and committed constituencies, and are growing in numbers. Our Elders Circle is fully launched and has already held 7 Circles.

iii. **Lessons Learned**: During the first two quarters of the grant, we have strengthened our recruitment and outreach processes, supported and expanded our Circle structures, and developed and improved our curricula for each of the Africentric Healing Circles.

We have significantly developed our evaluation process, creating a survey instrument that has been distributed to and completed by 49 of our Africentric Healing Circle participants, and has laid the foundation for a comprehensive evaluation process.

iv. **Relevant Examples of Success/Impact** (e.g. a client success story) Reminder: Please do not use real client names:

4th Quarter:

Quotations from Africentric Healing Circle Participants:

Through our survey instrument, we have collected a number of comments and quotes from Circle participants:

1. RJOY is extremely helpful in managing my mental and spiritual health. The facilitators are kind, honest, and powerful. Each circle has lived up to its name leaving me more joyful and more at peace. Bijon especially organically creates circles of accountability, solace, and laughter. Thank you for supporting this program. - QPOC Circle
2. Important work is done in these circles. I would be interested in similar circles being available in the Spanish-Speaking community. (I think there is a great need, especially in immigrant communities.) - Elders Circle
3. Amazing space to build community among women that look like me. - Sisters Rising
4. Enlightening - Sister's Rising
5. I feel good leaving the circle! - Sister's Rising
6. God Bless - Juvenile Hall Boys
7. I appreciate you guys! <3 - Juvenile Hall Boys
8. Good Job. Grateful for the lessons - Juvenile Hall Boys
9. It's very cool and fresh, of no disrespect - Peer Circle Cesar Chavez

3rd Quarter:

QPOC Circle: Our QPOC Queer People of Color Circles have been a safe space enabling Bay Area youth, young adults and adults to meet, build community, network, support, learn and heal using the guiding principles of restorative justice to tackle topics like "Growing Up Gay & Black" "Queering Gender" or "Unapologetic Authenticity." This weekly space is intentionally tailored to speak to the experiences of Queer-identifying folks of color and their allies for the sake of deeper and more nuanced conversation as it applies to our beloved bay area queer community. A recent example of the effectiveness of the QPOC Circle process comes from a young, Black, lesbian couple who found that the Circle could provide them with a safe and grounding space after finding that their relationship had been tested in other spaces (clubs, bars, etc.) They found that although these social spaces offered a good time, they also led to conflict, both between one another and with others.

While in Circle, the two shared deeply about their experiences as a couple and as individuals, trying to walk the tight rope at the intersection of the queerness, Black womanhood and unique complexities as human beings. They both talked about their own experiences with mental health and anxiety. We delved into the complexities of social media culture and its effect on our social lives. This particular Circle concluded with a "write and manifest" ritual that stressed the importance of physically writing your barriers to success and identifying specific life goals.

Peer Circle (Rockridge Branch): Peer Circles at the Rockridge Branch of the Oakland Public Library are an opportunity for youth to connect with one another on a regular basis, learn about restorative justice and acquire life skills for their mental, emotional and spiritual health, growth, and development. In this space, youth go deep in sharing their life experiences as well as participating in exercises and activities that model restorative justice, agency and accountability. There is also always a lot of food and a lot of fun. This group primarily serves youth of color who are Latinx or African-American middle school to high school aged. They come for the gift card incentives and end up leaving with so much more.

During one Circle, participants discussed Mental Health and Support: what support looks like, how to identify a need for it and where to meet the needs you've assessed. We filled out a "pod" worksheet identifying personal circles of support, institutional resources, and community resources that are always available.

This informed youth about access, resources, and agency in when and where to make use of them. They also had the opportunity to talk about what support does or does not look like in their life and how to build or maintain strong networks.

Camp Sweeney Community Restor-ganizing Circle (with young African American Men in juvenile detention): examines the relationship between the personal and the political. Through the use of theatre, hip hop, and other methods, youth explore the master narratives told about who they are and dream about who they want to become. During one Circle, which focused on Race and Police terrorism, we began with the song/video entitled Treat Me (Caucasian). The end of the video shows a series of video images that can be triggering. The images are of Black men and boys who have been brutalized by the police. The Circle participants were able to name many of the young men and boys, but they were also overwhelmed by the names they didn't know and the names and stories they mistook for the other. Tension rose in the room and the Circle Keeper stepped back, realizing that this was a moment of dreaming, then she asked a few specific questions. In their frustration and heaviness, participants were looking to the Circle Keeper for answers, but she urged participants to answer the questions themselves: *Will racism ever end? Why don't Africans like Black people? Why didn't the officer (who killed the young man) get convicted?* The Circles always end with the need for more time, more silence, more.

The Sisters Rising Circle has begun to explore our personal and collective relationships with racial identity, health, equity and healing. During one of the circles we opened with a song and a check-in question that related to the song. One of the participants started tearing up and mentioned that she always wanted to become a singer. She then began to share parts of her life story including going through the foster-care system and that now she is in a place in her life to reclaim love and power through her voice. We talked about how so many of us women of color are socialized to silence our truth and that manifests as illness in our bodies. We chose another song that was meaningful to that particular participant and she sang it while the RJOY Circle Keeper played guitar. The circle brought up a lot of past grief so we then closed the circle with a water cleansing and checked out with things we will like to call into our lives.

Additional Information

Please include the number of clients and/or contacts you estimate to serve in:

FY 19/20:
From January-July, 2019, RJOY reached 584 (unduplicated) participants through 12 Africentric Healing Circles (166 individual AA Healing Circles), two Racial Justice Community Healing Circles, one Africentric Celebration, one Community Healing Celebration and one RJOY Training Process. (We served our 584 participants through 1815 duplicated participant experiences.)

Our participant figures are already significantly higher than our original projections in our BHCS Grant Proposal, in which we committed to reaching 450 unduplicated participants in the first year of the project.

We committed to conducting a total of 10 Africentric Healing Circles, and we are now conducting 12 ongoing Circles (and 2 special circle processes.) We are at 166 individual African American Healing Circles, and are on track to double the number of Circles by the end of the first grant year.

Based on these figures, we anticipate that we will reach a total of at least 750 (unduplicated) participants in the first year of the project by continuing to conduct at least 10 Africentric Healing Circles, hosting two additional Africentric Celebrations (one in September and one in December), and conducting a two day Community Healing Training (August) and a two day RJOY Tier 1/Tier 2 Training (September.)

FY 20/21:

We plan to continue to conduct our Africentric Healing Circles in 2020-2021 (a minimum of 10 separate Circles), as well as Africentric Healing Celebrations, RJ Trainings and Community Healing Circles, reaching a minimum of 450 additional unduplicated individuals in that grant year.

Please tell us about any changes you intend to make to your program over the next two fiscal years and explain your rationale for making these changes: Click here to enter text.

Over the next two fiscal years, we intend to expand and solidify our Africentric Healing Circles Program, bringing in additional Circle Keepers who have received RJ Training through our Training Program, and finalizing individual curricula for each of the Circles. We plan to refine and modify our evaluation process by 1.) Improving our survey instrument; 2.) Developing an "age appropriate" survey process for our younger participants; 3.) Continuing to have Circle participants complete surveys. With the assistance of graduate students from Sacramento State University and under the supervision of our Executive Director, Dr. Teiahsha Bankhead, we will analyze the survey data and plan to complete an evaluation report by the end of the three year grant period which will provide valuable insight into the efficacy of the Africentric Healing Circles process. We will continue to develop our Ubuntu Healing Center (through separate funding sources) and will involve participants from our Africentric Healing Circles (particularly our young people coming out of juvenile detention) in this process, making the new Healing Center a source of healing and support for our most vulnerable participants.

[1] For purposes of this report, being "**at-risk**", can be widely defined your program/agency and can include various populations and groups such as TAY, being a person of color, single parent, immigrant, being over-stressed, former consumer/client, etc. Generally speaking any individual from the general public could be considered "at-risk" of developing some type of mental health issue.

[2] **Serious mental illness** per PEI regulations is defined as a mental illness that is severe in degree and persistent in duration, which may cause behavioral functioning which interferes substantially with the primary activities of daily living, and which may result in an inability to maintain stable adjustment and independent functioning without treatment, support, and rehabilitation for a long or indefinite period of time. These mental illnesses include, but are not limited to, schizophrenia, bipolar disorder, post-traumatic stress disorder, as well as major affective disorders or other severely disabling mental disorders.

[3] **Family Members** refer to family members (e.g. parents, grandparents, siblings, aunts, uncles) of the individual served by the PEI program that received some type of indirect services from your PEI funded program. For example, a parent of a child client who received information on how to follow up with a mental health treatment referral. Or a sibling who accompanied the individual to the service.

Prevention PEI Data Report FY 18/19

MHSA Program Number: PEI 20E
Program Name: Culturally Responsive PEI Programs for the African American Community-PEERS, Faith and Spirituality Based Program

Brand, implement and market Alameda County Interfaith and Spirituality Based Mental Illness Stigma Reduction mini-campaigns, advisory board meetings, stigma reduction support groups, and educational presentations that are placed-based, culturally-congruent, and trauma-informed through the lens of African Americans.

General Information & Total Numbers Served

Total Numbers Served through PEI MHSA		
Number of unduplicated individuals your program serves who are **at-risk** of developing a mental health problem or serious mental illness (SMI)	A	241
Number of unduplicated individuals your program serves who show **early signs** of forming a more severe mental illness	B	
Number of unduplicated individual family members served indirectly by your program:	C	
Grand TOTAL of unduplicated individuals served in the Quarter that you are reporting about. [This number (D) should = A+B+C.]	D	241

*Totals do not include email, outreach events, or community presentations/speaking engagements where people do not sign in

Type of Activity (ex: accessed website)	**Number of Individuals Reached** (#)
Email blasts of ECC-related articles and updates	2,495 subscribers
ECC Communications: Hard copy calendar updates	8,000 est. reached
African American ECC focus groups and Action Team meetings	29
Special Messages groups	49
Spirituality groups	30
Lift Every Voice and Speak (LEVS) speaking engagements	396
Tabling/outreach events	1,600 (approximately)
Community presentations	219

DEMOGRAPHICS

Age Group (Unduplicated)	
Children/Youth (0-15)	
Transition Age Youth (16-25)	21
Adult (26-59)	101
Older Adult (60+)	25
Unknown/ Declined to Answer	94

Race (Please mark only one choice) *If Hispanic or Latino, choose "Another race not listed."*	
American Indian or Alaska Native	
Asian	5
Black or African American	108
Native Hawaiian or other Pacific Islander	
White	40
More than one race	17
Another race not listed	30
Unknown/ Declined to Answer	41

Sexual Orientation (Please mark only one choice)	
Gay or Lesbian	
Heterosexual or Straight	38
Bisexual	2
Questioning or unsure of sexual orientation	
Queer	
Another sexual orientation not listed	2
Unknown/Decline to Answer	199

Ethnicity /Cultural Heritage (Please mark only once choice)	
If Hispanic or Latino, please specify:	
Caribbean	
Central American	
Mexican/Mexican--American/Chicano	3
Puerto Rican	
South American	
Another Hispanic/Latino ethnicity not listed	
Unknown/Declined to Answer	17
If Non-Hispanic or Non-Latino, please specify:	
African	1
African American	108
Asian Indian/South Asian	1
Cambodian	0
Chinese	1
Eastern European	0
European	3
Filipino	3
Japanese	1
Korean	0
Middle Eastern	1
Vietnamese	0
Other Non-Hispanic or Non-Latino ethnicity not listed	3
More than one ethnicity	3
Unknown /Declined to Answer	89

Primary Language (Please mark only one choice)	
English	58
Spanish	7
Farsi	
Cantonese	1
Mandarin	
Other Chinese Dialects	
Vietnamese	
Korean	
Tagalog	
Other Filipino Dialect	
Japanese	
Laotian	
Cambodian	
Mien	
Hmong	
Samoan	
Thai	
Russian	
Polish	
German	
Italian	
Turkish	
Hebrew	
French	
Portuguese	
Armenian	
Arabic	
Sign ASL	
Other primary language not listed	1
Unknown/ Decline to Answer	174

Gender Identity (Please mark both parts A & B)	
A) Assigned sex at birth: (Please mark only one choice)	
Male	
Female	
Other sex not listed (e.g. Intersex)	
Unknown/Decline to Answer	241
B) Current Gender Identity: (Please mark only one choice)	
Male	92
Female	108
Transgender	
Genderqueer	
Questioning or Unsure of Gender Identity	
Another Gender Identity not listed	1
Unknown/Decline to Answer	40

Disability Status (Please mark all that apply)	
None	0
Yes. If yes, please specify (choose from list below):	
Difficulty Seeing	
Difficulty hearing, or having speech understood	
Mental Domain	19
Physical/Mobility Domain	9
Chronic Health Condition	
Another disability not listed	
Unknown/Decline to Answer	213

Veteran Status (Please mark only one choice)	
Yes	4
No	56
Unknown/Decline to Answer	181

REQUIRED STRATEGY: IMPROVE TIMELY ACCESS TO MENTAL HEALTH SERVICES FOR UNDERSERVED POPULATIONS

a. Who is/are the underserved target population/s your program is serving (e.g. TAY, Southeast Asian, etc.)? Mental health consumers, primarily low-income people of color, including TAY and older adults.

b. Number of separate paper referrals to an ACBHCS PEI-funded program. (This can be a provider's internal ACBHCS PEI-funded prevention or early intervention program OR an external PEI-funded ACBHCS prevention or early intervention program): 1

c. Number of individuals followed through on referral & engaged in an ACBHCS PEI-funded program: 0

d. Average time in weeks between when a paper referral was given to individual by your program and the individual's first in person appointment with the ACBHCS PEI-funded provider. N/A The referrals were not for "appointments" per se. One participant, who has a TAY-aged child struggling with mental health challenges, was referred to Intensive Home Outreach Team (IHOT). Other referrals were to programs not funded by ACBH PEI, such as 2-1-1 for the Consolidated Entry System. For example, we provided one participant with referrals to BayLegal's Alameda County Tenants' Rights Hotline (and 2-1-1) for advice on negotiating with his landlord and he was able to avoid eviction.

e. Describe ways your program encouraged access to services and follow-through on the above referrals: Our primary method is to provide both information about participants' options and personal encouragement, since self-determination is a core principle of our program model.

NARRATIVE

a. Choose two of the above principles and describe how your program upholds or achieves those principles. Please speak to each principle separately and specifically describe how your program activities align with that corresponding principle.

   Principle #1: Cultural Competence How does your program align with this principle? PEERS has provided culturally competent services with cultural humility for African Americans with mental health challenges for many years. One example of our practice of cultural competence is our African American Everyone Counts Campaign. FY18-19 was the planning year for this campaign, which builds on PEERS' Latino Everyone Counts Everyone Counts Campaign (FY16-17 and FY17-18) and Chinese American Everyone Counts Campaign (FY14-15 and FY15-16). The campaign is staffed and led by African Americans, all of whom have lived experience with mental health challenges. Some elements of African American culture that have been incorporated into the planning of the campaign include taking a trauma-informed approach, incorporating culturally-informed ritual into meetings and other gatherings, and making room for talking about religion and belief systems, as well as shared histories of oppression and current experiences of racism. The campaign is guided by an African American Action Team, composed of a diverse group of 16 African American community members with lived experience of mental health challenges. One of Action Team's charges this year was to identify a group with the power and influence to reduce stigma around mental health in the local African American community. The Action Team decided that people in the music and entertainment industries have that kind of influence. We are in the process of recruiting influential artists and media producers to the campaign, including Mistah Fab, So Oakland, and KPFA.

   Principle #2: Wellness and Recovery How does your program align with this principle? All of the community outreach (both in-person and online) PEERS does through the Everyone Counts Campaign is strongly grounded in messages of wellness and recovery. From our "Love More, Judge Less" t-shirts, to our insistence on using non-stigmatizing recovery-based language instead of diagnostic or symptom-focused language, to the many ways that our staff act as living models of the possibility of wellness and recovery, PEERS aligns with this principle consistently. Our Lift Every Voice and Speak speakers' bureau (LEVS), promotes wellness and recovery by training people with lived experience of mental health challenges to tell their recovery stories, including how different forms of stigma have affected them. By telling their stories, LEVS speakers introduce wellness and recovery perspectives to audiences of other mental health consumers as well as to

community members who may not have similar experiences. The speakers' bureau enhances the wellness of LEVS speakers themselves by building supportive peer relationships, developing leadership, and improving their community by taking action to reduce stigma.

b. Please tell us about the following…

i. Implementation Challenges: At the beginning of FY18-19, attendance at LEVS meetings was lower than we wanted, with an average attendance of eight participants during the first quarter. To increase engagement, we revamped the meetings and the speaker training curriculum. We incorporated more healing and wellness tools into the meetings, including art activities and small-group sharing. The program coordinator implemented a new system for supporting each speaker to move toward her or his own speaking goals. We also brought more structure to the speaker trainings, so that members were better able to support each other to improve their effectiveness as speakers. Additional training on the different forms of stigma related to mental health challenges (public stigma, structural stigma, and self stigma) also deepened speakers' ability to link their personal stories to stigma reduction. On another note, at the end of FY17-18, we redesigned our spirituality program to emphasize facilitating groups at other places where people gather rather than at PEERS, because we were not satisfied with the level of attendance at our spirituality groups. To that end, we developed a new partnership with Allen Temple Arms, an affordable housing complex for low-income seniors and people with disabilities. Not only were the spirituality groups well received by the residents, but PEERS' partnership with Allen Temple Arms expanded beyond the spirituality program.

ii. Successes: The African American Everyone Counts Campaign has had some major successes in getting media coverage. In July, Bre Williams, PEERS' Programs Manager, was featured on an hour-long show on KPFA radio that explored questions including what it means to be mentally and emotionally healthy, why mental, emotional, and physical health often are understood as separate, how dominant cultural norms frame understanding of health and illness -- and more healthful and culturally relevant ways to understand mental health. In November, PEERS' Executive Director Vanetta Johnson along with staff members Bre Williams and Ashlee Jemmott were featured on the KBLX radio show "Listen Up Bay Area," which features local organizations. In a 15-minute segment, they discussed key themes related to mental health among African Americans, including the goals of the African American Everyone Counts Campaign. In the spring, the campaign was again featured on KPFA during KPFA's coverage of Oakland's Juneteenth celebration. As for Lift Every Voice and Speak, the changes to the speakers' bureau program were so successful that by the fourth quarter, average attendance at meetings increased to 18 and membership increased to 30. The program currently is at capacity and we have suspended recruitment of new members.

iii. Lessons Learned: During the planning phase for the two-year African American Everyone Counts Campaign, PEERS held a series of focus groups -- one for high-school aged young men, one for high-school aged young women, and one for elders. Each group discussed what they need in their neighborhoods to thrive and be successful; what cultural competency means to them; what supports, skills, and resources they need in order to develop healthier self-esteem; and what would help them be more prepared to respond to the daily stressors associated with racism, discrimination, and other forms of systematic oppression. Themes that emerged in all three groups included attention to the social determinants of health such as the need for good jobs, access to healthy food and grocery stores, role models, and support (e.g. "Neighborly love - someone to talk to about real stuff."). Young women strongly expressed the need for safety in many settings, especially safety from physical and sexual violence. Young men talked about needing to know more about their history and the histories of their people. When discussing cultural competency, focus group participants articulated the need to be understood. One young woman said, "Doctors need to be aware of black people's humanity." An elder participant pointed out, "Not all black people are the same." Another elder participant described how, as a black man, he has to set his mental health providers at ease and make the provider feel comfortable in order to get services. As we move into the next stage of the campaign, we will incorporate what we have heard so far, and continue to seek out the insights of more African American community members.

iv. Relevant Examples of Success/Impact (e.g. a client success story) Reminder: Please do not use real client names: The LEVS speakers' bureau program coordinator implemented a new system for supporting each speaker to move toward her or his own goals. At the beginning of the year, or upon joining LEVS, each speaker is given the option of setting an individual goal. The program coordinator then adapts the curriculum and designs opportunities to assist each participant to pursue their goal. LEVS participants recently described the group as "a speakers' bureau for healers," and "a healing community that helps spread hope." One member of the speakers' bureau said that she now is "speaking in a voice I didn't know I had."

ADDITIONAL INFORMATION

Please include the number of clients and/or contacts you estimate to serve in:

FY 19/20: 275 (does not include email, outreach events, or community presentations/speaking engagements where people do not sign in)

FY 20/21: 275 (does not include email, outreach events, or community presentations/speaking engagements where people do not sign in)

Please tell us about any changes you intend to make to your program over the next two fiscal years and explain your rationale for making these changes: The two primary changes to PEERS ECC programs in the next two years will be in the ethnic-specific social inclusion campaigns and in the Programa Anti-Stigma Latino (PAL). In FY 19-20, we will move from planning to implementation of the African American Everyone Counts Campaign, which includes facilitating two multi-session stigma reduction support groups. In FY 20-21, we expect to be in a planning year for another culture-specific Everyone Counts Campaign. In FY 19-20, we also will begin implementation of PAL, a Latino-focused anti-stigma program that will include peer support groups and community presentations.

Prevention PEI Data Report FY 18/19

MHSA Program Number: PEI 23
Program Name: Post Crisis Peer Mentoring

Post Crisis Peer Mentoring program offers brief low-intensity early intervention through peer support to address and promote recovery, and to prevent relapse. The program engages mentors and participants whereby each mentor serves as a facilitator with the participant on the participant's path to self-discovery and self-determination.

GENERAL INFORMATION & TOTAL NUMBERS SERVED

Total Numbers Served through PEI MHSA		
Number of unduplicated individuals your program serves who are at-risk of developing a serious mental illness (SMI)	A	132
Number of unduplicated individuals your program serves who show early signs of forming a more severe mental illness	B	132
Number of unduplicated individual family members served indirectly by your program:	C	
Grand TOTAL of unduplicated individuals served in the Quarter that you are reporting about. [This number (D) should = A=B+C.]	D	132

DEMOGRAPHICS

Age Group (Unduplicated)	
Children/Youth (0-15)	0
Transition Age Youth (16-25)	35
Adult (26-59)	83
Older Adult (60+)	14
Unknown/ Declined to Answer	0

Race (Please mark only one choice) *If Hispanic or Latino, choose "Another race not listed."*	
American Indian or Alaska Native	1
Asian	9
Black or African American	42
Native Hawaiian or other Pacific Islander	
White	29
More than one race	2
Another race not listed	
Unknown/ Declined to Answer	

Sexual Orientation (Please mark only one choice)	
Gay or Lesbian	2
Heterosexual or Straight	66
Bisexual	1
Questioning or unsure of sexual orientation	1
Queer	
Another sexual orientation not listed	1
Unknown/Decline to Answer	20

Ethnicity /Cultural Heritage (Please mark only once choice)	
If Hispanic or Latino, please specify:	
Caribbean	1
Central American	
Mexican/Mexican--American/Chicano	1
Puerto Rican	
South American	
Another Hispanic/Latino ethnicity not listed	13
Unknown/Declined to Answer	
If Non-Hispanic or Non-Latino, please specify:	
African	1
African American	
Asian Indian/South Asian	
Cambodian	
Chinese	4
Eastern European	
European	
Filipino	
Japanese	
Korean	
Middle Eastern	2
Vietnamese	
Other Non-Hispanic or Non-Latino ethnicity not listed	
More than one ethnicity	
Unknown /Declined to Answer	

Primary Language (Please mark only one choice)	
English	101
Spanish	15
Farsi	
Cantonese	8
Mandarin	
Other Chinese Dialects	
Vietnamese	
Korean	
Tagalog	
Other Filipino Dialect	
Japanese	
Laotian	
Cambodian	
Mien	
Hmong	
Samoan	
Thai	
Russian	
Polish	
German	
Italian	
Turkish	
Hebrew	
French	
Portuguese	
Armenian	
Arabic	2
Sign ASL	
Other primary language not listed	
Unknown/ Decline to Answer	6

Gender Identity (Please mark both parts A & B)	
A) Assigned sex at birth: (Please mark only one choice)	
Male	72
Female	60
Other sex not listed (e.g. Intersex)	
Unknown/Decline to Answer	
B) Current Gender Identity: (Please mark only one choice)	
Male	
Female	
Transgender	
Genderqueer	
Questioning or Unsure of Gender Identity	
Another Gender Identity not listed	

Disability Status (Please mark all that apply)	
None	63
Yes. If yes, please specify (choose from list below):	
Difficulty Seeing	3
Difficulty hearing, or having speech understood	5
Mental Domain	20
Physical/Mobility Domain	22
Chronic Health Condition	5
Another disability not listed	
Unknown/Decline to Answer	12

Veteran Status (Please mark only one choice)	
Yes	
No	80
Unknown/Decline to Answer	2

REQUIRED STRATEGY: IMPROVE TIMELY ACCESS TO MENTAL HEALTH SERVICES FOR UNDERSERVED POPULATIONS

a. Who is/are the underserved target population/s your program is serving (e.g. TAY, Southeast Asian, etc.)? Services are provided to transition-age youth, adults and older adults being discharged or dispositioned from John George Psychiatric Hospital inpatient hospital services.

b. Number of separate paper referrals to an ACBHCS PEI-funded program. (This can be a provider's internal ACBHCS PEI-funded prevention or early intervention program OR an external PEI-funded ACBHCS prevention or early intervention program): 132

c. Number of individuals followed through on referral & engaged in an ACBHCS PEI-funded program: 132

d. Average time in weeks between when a paper referral was given to individual by your program and the individual's first in person appointment with the ACBHCS PEI-funded provider. N/A

e. Describe ways your program encouraged access to services and follow-through on the above referrals: N/A However, while the participant is engaged with the peer mentor, the mentor is informed by the participant in terms of participant's needs. The mentor will then, together with the participant, assist the participant in navigating the mental health system in order to help the participant find the appropriate services that best fits the participant's needs.

Narrative

a. Choose two of the above principles and describe how your program upholds or achieves those principles. Please speak to each principle separately and specifically describe how your program activities align with that corresponding principle.

Principle #1: Wellness and Recovery. How does your program align with this principle? For the Mentor to be able to connect with a patient while they are in a facility, and before they are discharged, provides an opportunity to eliminate the disconnect between being served in a facility and reconnecting to community. The peer mentors are dedicated to serving those who suffer from serious and persistent mental illness in order to alleviate suffering. Through partnerships with community organizations, local government entities, and public agencies, our peer mentor program works to address issues that affect overall community health. The peer mentor interacts with the patient in order to understand and help address the needs of the patient. Considering the patient is being served in a psychiatric facility, the objective of the peer mentor is not simply reduce re-hospitalization rate of patients; but to help the participants improve the quality of their life within the community once they are discharged. Our adult peer mentor program's primary focus is to serve the mentor health population in Alameda County who suffers from serious and persistent mental illness. It is an opportunity for those who have struggled with mental illness to gain confidence and to receive additional support within a one on one relationship for an extended period of time.

Principle #2: Integrated Service Delivery. How does your program align with this principle? All efforts are made to assign a peer mentor to a patient before the patient is discharged from a mental health facility. At the point of introduction, the trained peer mentor will attempt to make a meaningful connection with the patient at the facility. At the patient's request, the mentor will continue to visit the patient until the patient is discharged. And while still at the facility, the mentor and patient will agree to maintain that connection into the community where the patient lives. Before discharge, the mentor and patient will agree to contact each other on a weekly basic- both by phone and in person. The in-person meeting will be arranged by phone or text. It is an opportunity for those who have struggled with mental illness to gain confidence and to receive one on one support in addition to having a case manager and, or a therapist. At the request of the patient, the mentor is willing to share his or her individual experiences of recovery and transformation; and connecting with a peer mentor is a way for a person to connect with someone not unlike themselves, and who may have gone through similar circumstances. Parents of the patient are very welcoming to the mentor-patient relationship. Parents view such relationships as additional community support; and many parents may not have quality time to devote to this type of support, are unfamiliar with the mental health system of services. One example is: The peer mentors will assist their participants with obtaining community resources such as housing, obtain a free phone from various providers, connect to mental health support groups in addition to a one on one connection. Also, the peer mentor can assist the patient to collaborate with other community providers who offers services for both patient and family.

b. Please tell us about the following…

i. Implementation Challenges: One ongoing challenge is to recruit, train, and retain mentors who are totally committed to the process of serving others. Other challenges are facilitating patients who don't have a

phone and who may refuse assistance to obtain a free phone. Another challenge is no shows: when a participant constantly make arrangements to meet with mentor; but does not show. Mentor must then re-navigate boundaries with participant in order for the relationship to remain fruitful.

ii. Successes: Mentors have learned to better understand the many challenges faced by the participant. Such could be issues with home environment, lack of employment, the Participant not being able to think clearly and critically. The mentor, by relying on the training and personal experiences, have been able to be more empathetic toward providing services to Participants. And by being patient and caring, the Mentor is able to form a more productive relationship with the participant. In this manner of care, serving the participant has become more personable, and the Mentor has become truly invested in the well-being of the Participant. This has led to the development of more trust between the two.

iii. Lessons Learned: Mentors who are committed to the process are critical to its success; and among this process is to introduce the participant to as many community services as available to help the participant facilitate his or her own needs. Once trust is firmly established between Mentor and Participant, the participant will open up and share with the Mentor how the Mentor can be of service.

iv. Relevant Examples of Success/Impact (e.g. a client success story) Reminder: Please do not use real client names: One of the challenges I faced was a participant who was homeless. We overcame this problem when he was sent to Jay Mahler rehab facility from John George Hospital and with help from the social workers and myself, 'client' was referred to East Oakland Community Project/Crossroads which is transitional housing. He will apply for permanent subsidized housing for the next 9-12 months from that facility." One participant was connected with a mentor for a few months; and the patient was in the process of taking the CPA exam. He passed it and is now back at work doing accounting. One participant was connected with a mentor with a drinking issue; but she is now going to barber college. Drinking issue remains a challenge.

Evaluation Plan Update

Each PEI program must collect information **on client/participant experience, feedback, or satisfaction** with the programming provided.

a. Please describe, in 1-2 sentences, your effort to collect feedback from program participants (method used). Please include the timeframes of when you survey clients.
Each month as the patient and mentor interact, the patient will fill out a Hope and Isolation Scale. The intent of this scale is to measure improvement of the patient's feeling of isolation and hopelessness.

b. Describe the tool (i.e. MHSIP or another survey) used to collect data.
We implemented the Hope and Isolation Scale, a 12 question survey with the goal of measuring the development of the patient while in relationship with the mentor. Going forward, we plan to use the MHSIP as mentioned above.

c. Summarize the results if any. In general the program was successful in that it enabled patients who previously endorsed feelings of hopelessness to experience greater positive views of their future when they successfully navigated the program. A larger more focused evaluation of the program is needed to determine whether part of the success may be attributed to factors associated with those participants who remain engaged with their Mentor (remain in the program) as opposed to those who drop out early on/ those who are less connected with their Mentor. In other words, there may be some commonalities among those who experience greater success and report more hopefulness (and therefore complete the tool) as opposed to others who may not consistently complete the program or self-report measures.

d. What was learned from the participant feedback (**1-2 key points**)? Providing participants with mentorship and real time guidance navigating the system; including those which resulted in actual linkages seemed to be associated with reported feelings of increased hopefulness. Patients who also received more contact and support from their community based programs also showed less isolation and more self-efficacy overall.

e. Describe how the findings were reviewed by staff. Findings were discussed with AHS leaders and NAMI staff during several program update meetings. Discussions revealed that the initial referrals by the social workers were successful in identifying potential matches with the program; but did also highlight that the level of engagement post-discharge could not always be predicted.

f. What programmatic change(s) were or will be adopted as a result of the findings? When will changes be made and how will the changes impact programming? Findings (described above) have been relayed to Social Work Supervisor and have been discussed with the team in relation to identifying patients who would benefit from the program. However, this contract has not been renewed for FY20.

g. What issues or challenges with the Evaluation Plan are you having? What technical assistance do you need? NONE

ADDITIONAL INFORMATION.

Please include the number of clients and/or contacts you estimate to serve in:

FY 19/20: Minimum 100
FY 20/21: Minimum 100

Please tell us about any changes you intend to make to your program over the next two fiscal years and explain your rationale for making these changes: Would like to focus more on improvement on the quality of life after discharge and not place a considerable emphasis simply to reduce hospital beds (which was the original intent of the mentoring program) without having the same consideration for how the mentoring improves the overall quality of life after the patient is discharged. The rational in this is: the patient comes from an environment whereby much focus should ultimately be given to where the patient will be returning (thus the focus of the Mentor). Further change would be to extend the mentoring process into PEI, and to have mentors come to each Unit on a weekly basic to inform patient of the mentoring process.

Prevention PEI Data Report FY 18/19

MHSA Program Number: PEI 24
Program Name: Sobrante Park Community Project- Roots Community Health Center

Sobrante Park Mental Illness Prevention services - increasing protective factors and decreasing risk factors for families, community beautification and career readiness and exploration for junior and senior high school students.

General Information & Total Numbers Served

Total Numbers Served through PEI MHSA	CATEGORY 1: MENTAL HEALTH & WELLNESS	CATEGORY 2: NEIGHBORHOOD BEAUTIFICATION	CATEGORY 3: CAREER EXPLORATION
A:Number of unduplicated individuals your program serves who are at-risk of developing a mental health problem or serious mental illness (SMI)	33		32
B: Number of unduplicated individuals your program serves who show early signs of forming a more severe mental illness	3		0
C: Number of unduplicated individual family members served indirectly by your program:	8		0
D: Grand TOTAL of unduplicated individuals served in the Quarter that you are reporting about. 44 32			
Ethnicity /Cultural Heritage (Please mark only once choice)			
If Hispanic or Latino, please specify:			
Caribbean			
Central American			
Mexican/Mexican-American/Chicano	3		
Puerto Rican			
South American			
Another Hispanic/Latino ethnicity not listed			
Unknown/Declined to Answer	12		20
If Non-Hispanic or Non-Latino, please specify:			
African			

African American	**14**		**11**
Asian Indian/South Asian			
Cambodian			
Chinese			
Eastern European			
European	**1**		
Filipino			
Japanese			
Korean			
Middle Eastern			**1**
Vietnamese			
Other Non-Hispanic or Non-Latino ethnicity not listed			
More than one ethnicity			
Unknown /Declined to Answer	**6**		
Age Group (Unduplicated)			
Children/Youth (0---15)	**10**		
Transition Age Youth (16---25)	**14**		**32**
Adult (26---59)	**11**		
Older Adult (60+)	**1**		
Unknown/ Declined to Answer			
Race (Please mark only one choice) *If Hispanic or Latino, choose "Another race not listed."*			
American Indian or Alaska Native			
Asian	**1**		
Black or African American	**14**		**11**
Native Hawaiian or other Pacific Islander			
White	**1**		**1**
More than one race			
Another race not listed	**15**		**20**
Unknown/ Declined to Answer	**5**		
Primary Language (Please mark only one choice)			
English	**34**		**32**
Spanish	**2**		
Farsi			
Cantonese			
Mandarin			
Other Chinese Dialects			
Vietnamese			
Korean			
Tagalog			

Other Filipino Dialect			
Japanese			
Laotian			
Cambodian			
Mien			
Hmong			
Samoan			
Thai			
Russian			
Polish			
German			
Italian			
Turkish			
Hebrew			
French			
Portuguese			
Armenian			
Arabic			
Sign ASL			
Other primary language not listed			
Unknown/ Decline to Answer			
Gender Identity			
Assigned sex at birth: (Please mark only one choice)			
Male	19		19
Female	16		13
Other sex not listed (e.g. Intersex)			
Unknown/Decline to Answer	1		
Current Gender Identity: (Please mark only one choice)			
Male	19		19
Female	16		13
Transgender			
Genderqueer			
Questioning or Unsure of Gender Identity			
Another Gender Identity not listed			
Unknown/Decline to Answer	1		
Sexual Orientation (Please mark only one choice)			
Gay or Lesbian			
Heterosexual or Straight			
Bisexual	1		

Questioning or unsure of sexual orientation			
Queer			
Another sexual orientation not listed			
Unknown/Decline to Answer	**35**		**32**
Disability Status (Please mark all that apply)			
None	**3**		
Yes. If yes, please specify (choose from list below):			
Difficulty Seeing			
Difficulty hearing, or having speech understood			
Mental Domain			
Physical/Mobility Domain			
Chronic Health Condition			
Another disability not listed			
Unknown/Decline to Answer	**33**		**32**
Veteran Status (Please mark only one choice)			
Yes			
No			
Unknown/Decline to Answer	**36**		**32**

REQUIRED STRATEGY: INCREASE ACCESS AND LINKAGE TO MENTAL HEALTH TREATMENT

a. Number of individuals with serious mental illness (SMI) who received a paper referral (i.e. referrals via phone do not apply) from your program to an ACBHCS mental health treatment program: *0*

b. List type(s) of mental health treatment programs the individual was referred to: *N/A*

c. Number of individuals who were successfully referred and linked to an ACBHCS mental health treatment program (i.e. client has been seen at least once in person by a treatment provider): *N/A*

d. Average duration in weeks of signs of untreated mental illness (per client self-report): *104*

e. Average time in weeks between when a paper referral was given to individual by your program and the individual's first in person appointment with a mental health treatment provider: *N/A*

f. Any additional information to report on? (Optional): No clients have been externally referred for mental health treatment programs. One client was already connected to Roots' LCSW prior to engaging with our Sobrante Park work. Two (2) clients requiring services for mild-moderate mental illness have been referred to and seen by Roots' LCSW. Navigators are still searching for appropriate care for a Spanish-speaking client.

REQUIRED STRATEGY: IMPROVE TIMELY ACCESS TO MENTAL HEALTH SERVICES FOR UNDERSERVED POPULATIONS

a. Who is/are the underserved target population/s your program is serving (e.g. TAY, Southeast Asian, etc.)? Individuals and families of African and Latino/a decent living in/attending school in Sobrante Park.

b. Number of separate paper referrals to an ACBHCS PEI-funded program. (This can be a provider's internal ACBHCS PEI-funded prevention or early intervention program OR an external PEI-funded ACBHCS prevention or early intervention program): 8 this quarter, 78 since program inception (all for internal program)

c. Number of individuals followed through on referral & engaged in an ACBHCS PEI-funded program: 5 this quarter, 46 since program inception

d. Average time in weeks between when a paper referral was given to individual by your program and the individual's first in person appointment with the ACBHCS PEI-funded provider. 1 week

e. Describe ways your program encouraged access to services and follow-through on the above referrals: Phone calls to client and client's family members, visiting with clients in familiar spaces (home, school), offering incentives to participation

f. Any additional information to report on (optional): N/A

Number of potential responders: 249

List type of setting(s) in which the potential responders received outreach and the type(s) of potential responders engaged in each setting:

Type of Setting(s) (ex: school, place of worship, clinic)	**Type(s) of Potential Responders** (ex: principals, teachers, parents, nurses)
SP Health & Wellness Fair	Community members
Neighborhood Empowerment Day	Community members
Madison Park Academy	Students, parents, counselors

NARRATIVE

a. Choose <u>two</u> of the above principles and describe how your program upholds or achieves those principles. Please speak to each principle separately and specifically describe how your program activities align with that corresponding principle.

b. Principle #1: **Cultural Competence**
How does your program align with this principle?

Our Navigators reflect the population served in Sobrante Park (1 African American man; 1 Latina and Spanish-speaking). All physical and mental health providers also reflect the demographics of the population. We provide services in the languages spoken by our clients. Staff have life experiences similar to the clients with whom they are working. Services are also provided in a comfortable, non-stigmatizing environment. Youth clients are invited to utilize our Dream Youth Clinics for adolescent and transitional age youth where staff create an inviting and safe space for youth to engage. All clients have access to Roots Community Market, where they can use a point system to select a bag of fresh groceries with a set of recipes representing the various cultures of our clients.

Principle #2: **Community Collaboration**
How does your program align with this principle?

Community Collaboration is at the foundation of this scope of work. We work closely with the Sobrante Park Resident Action Council to ensure residents are engaged in the strategies being implemented within the neighborhood. We have also been meeting with key staff at the schools to ensure that we are familiar with their challenges and adding value. We have been building strong relationships with other partners to provide services in Sobrante Park and across all sites. This includes legal services from Centro Legal de La Raza; offering clients opportunities for employment with hiring partners through our Empowerment Center; and conducting housing assessments for unhoused clients through the Coordinated Entry System. Our network of partners continues to expand, leading to a broader array of resources available to our clients and attendees at all of our community events.

b. Please tell us about the following

i. Implementation Challenges: In the fourth quarter, we identified significant differences in interpretation of the role of Roots on the school campus as it relates to the Center for Healthy Schools and Communities (CHSC) COST Team at MPA, school staff, and our on-campus partner Higher Ground. At some point in March, we discovered that CHSC had expressed its understanding that all referrals (including those from Higher Ground) had to come through the COST team. As a result, we did not receive any referrals from Higher Ground after that point (some time in February). In addition, the COST team agreed to send us only a small number of referrals as a “trial run,” significantly limiting the number of MPA students with whom we could work. We did not realize this was happening until much later. We subsequently had a series of meetings towards the end of the fiscal year to get on one accord regarding referrals. In addition, we have met with staff on the primary campus, as well as Native American Health Center staff to further partnerships that address the needs of families and fill current service gaps.

   Finally, because of the shortened period of this contract (9 months rather than a full year), our proposed numbers served should have been altered to reflect 75% of the full amount. In addition, because this was our first year doing this scope of work, the first 3 months were a start-up period and services did not fully begin until January 2019.

ii. Successes: On June 22nd, we had our third community engagement event, the Sobrante Park Health &Wellness Fair, with 23 attendees. This event was hosted by the Sobrante Park RAC and Roots’ navigation and clinic staff attended to provide services. While the turnout for this event was lower than expected, Roots has provided outreach ideas to the RAC and will make Roots outreach staff available for outreach efforts for future events.

Partners offering services at this event included Healthy Teeth Healthy Communities, Roots' mobile clinic, Oakland Fire Dept., Oakland Police Dept., CA Highway Patrol, East Bay Moms Demand Action, Planting Justice, Sobrante Park Resident Action Council, East Oakland Neighborhood Initiative, and a backpack giveaway.

Roots also supported the Sobrante Park RAC in their hosting of an Earth Day community beautification event on April 20th. Participants cleaned up litter and planted flowers and trees throughout the neighborhood.

Roots' Navigators were approved for full access to Madison Park Academy and Lionel Wilson via a formal MOU with OUSD. This has led to an increase in students and families served as we are able to meet with clients in spaces more accessible to them. Our Navigators have also increased their skill in serving families as a unit but also as individuals, engaging multiple members of families in services.

More than 24 students (32 juniors and seniors) have been served by the stipend career paths and employment readiness and exploration program hosted by Higher Ground. For navigated students unable to participate in this program, Navigators have facilitated linkages with other summer youth employment opportunities including Youth Uprising, YEP, and Roots' Oakland Unite Summer Nights Planning Committee.

iii. Lessons Learned: In our work with our partners, we have learned it is best to have our partners send regular (monthly) reports of their activities to maintain accountability and ensure timeliness of quarterly reporting. In our work with community members, we have recognized the need for additional legal service providers (including in Spanish) to assist with immigration, criminal, tenancy, and family legal issues that many of our clients are facing. We are actively working to bolster these existing partnerships and increase the regularity and accessibility of services.

For engaging with clients, we have found the best referrals to be those that come from existing clients. People are more likely to follow up when they know another client engaged in services. For some referrals we received from partners, we realized the clients they were referring may not have the most intense level of need as they are already engaged in other services. We have tried to focus our reach to those who are not engaged in other programs since they are most likely to be at risk of developing severe mental illnesses. Some of the students who were referred to us by Madison Park Academy have very complex needs outside the scope/training of family Navigators. We are working to match the expertise of program staff with the needs expressed by the school to ensure these students have access to all the support services (academic, health, financial, etc.) they need (see Section 8 for details).

iv. Relevant Examples of Success/Impact (e.g. a client success story) Reminder: Please do not use real client names: *Recounted by Roots Sobrante Park Navigator:* "'Rodney' came to Roots one day and was visibly in emotional distress. Teary-eyed, he sat down and began to explain his story to me. He started by explaining why he was so emotional. He said the one year anniversary of his mother's death was in a couple of days and she was his world. He then went on to talk about how he was going through a rough patch in life and didn't have many social supports.

v. And, although he has three siblings (sisters), only one is somewhat supportive – to an extent. As our conversation went on he talked about how his life had been going in a downward spiral since a shoulder injury left him temporarily disabled. Before the injury, Rodney was a unionized sprinkle fitter and making upward of $60/hr. Rodney was also a single parent raising his only son, up until and for some time after his injury. However, the time that he raised his son after his injury was short lived. They were moving from hotel to hotel - because of his limited income (SDI), it was the only thing he could afford. He eventually realized that the best

thing for his son was to go live with his maternal grandmother out of state, a painstaking decision that has left him and his son's relationship strained. While living on his own now, Rodney was able to convince one of his sisters, who lives in Sobrante Park, to let him live in her backyard until he got on his feet; something that he'd be willing to do for himself, but not if he still had his son in his custody.

Shortly after our conversation, we began working on a plan to get Rodney back on his feet. We took care of his immediate needs which were food, clothing and a bus pass. We went to Roots Community Market (Roots' food pantry) and got him a few items to last him for a few days. We then went upstairs to our men's clothing closet and picked out a couple of slacks, blazers, collared shirts and dress shoes. I then gave Rodney a bus pass and an ID Voucher. Our next step was to get reinstated into the sprinkle fitters union and find temporary housing. After several weeks we were able to get Rodney into "Turning Point," Roots' Emergency Bridge Housing, and pay for his union dues. To date, Rodney has been reinstated into the union and is getting together the tools, equipment and working clothes needed for his line of work."

Additional Information

Please include the number of clients and/or contacts you estimate to serve in:

FY 20/21: 64

Please tell us about any changes you intend to make to your program over the next two fiscal years and explain your rationale for making these changes: (1) We will include Outreach Specialist time to increase referrals for services and outreach for events, (2) we will include a new partner, Timebanking, to implement Timebanking in Sobrante Park. This will be used as a tool to build community, increase engagement, and create an additional incentive for program participants, (3) we will incorporate a 0.5 FTE Navigator specializing in adolescent navigation in an effort to be responsive to the needs of the school as expressed by the Center for Healthy Schools and Communities. We will commensurately decrease family navigators from 2.0 FTE to 1.5 FTE resulting in no net change in navigator time, and (4) we are increasing program coordinator time given the diverse scope of work and coordination of multiple partners.

Prevention and Early Intervention PEI Data Report FY 18/19

MHSA Program Number: PEI 2
Program Name: Early Intervention for the Onset of First Psychosis & SMI among TAY –Prevention and Recovery in Early Psychosis (Prep)

PREP provides evidence-based treatment and support for transition age youth (TAY) experiencing an initial episode of psychosis.

General Information & Total Numbers Served

Total Numbers Served through PEI MHSA		
Number of unduplicated individuals your program serves who are **at-risk** of developing a mental health problem or serious mental illness (SMI)	**A**	58
Number of unduplicated individuals your program serves who show **early signs** of forming a more severe mental illness	**B**	58
Number of unduplicated individual family members served indirectly by your program:	**C**	26
Grand TOTAL of unduplicated individuals served in the Quarter that you are reporting about. [This number (D) should = A+B+C.]	**D**	84

DEMOGRAPHICS

Age Group (Unduplicated)	
Children/Youth (0---15)	0
Transition Age Youth (16---25)	58
Adult (26---59)	0
Older Adult (60+)	0
Unknown/ Declined to Answer	0

Race (Please mark only one choice) *If Hispanic or Latino, choose "Another race not listed."*	
American Indian or Alaska Native	0
Asian	1
Black or African American	19
Native Hawaiian or other Pacific Islander	2
White	9
More than one race	6
Another race not listed	20
Unknown/ Declined to Answer	1

Sexual Orientation (Please mark only one choice)	
Gay or Lesbian	0
Heterosexual or Straight	42
Bisexual	6
Questioning or unsure of sexual orientation	1
Queer	0
Another sexual orientation not listed	0
Unknown/Decline to Answer	9

Ethnicity /Cultural Heritage (Please mark only once choice)	
If Hispanic or Latino, please specify:	
Caribbean	0
Central American	8
Mexican/Mexican-American/Chicano	9
Puerto Rican	0
South American	1
Another Hispanic/Latino ethnicity not listed	2
Unknown/Declined to Answer	0
If N on-Hispanic or Non-Latino, please specify:	
African	18
African American	0
Asian Indian/South Asian	3
Cambodian	0
Chinese	0
Eastern European	0
European	3
Filipino	1
Japanese	0
Korean	0
Middle Eastern	1
Vietnamese	0
Other Non-Hispanic or Non-Latino ethnicity not listed	3
More than one ethnicity	7
Unknown /Declined to Answer	2

Primary Language (Please mark only one choice)	
English	48
Spanish	8
Farsi	0
Cantonese	0
Mandarin	0
Other Chinese Dialects	0
Vietnamese	0
Korean	0
Tagalog	1
Other Filipino Dialect	0
Japanese	0
Laotian	0
Cambodian	0
Mien	0
Hmong	0
Samoan	0
Thai	0
Russian	0
Polish	0
German	0
Italian	0
Turkish	0
Hebrew	0
French	0
Portuguese	0
Armenian	0
Arabic	0
Sign ASL	0
Other primary language not	0
Unknown/ Decline to Answer	1

Gender Identity (Please mark both parts A & B)	
A) Assigned Sex at Birth (Please mark only one choice)	
Male	40
Female	16
Other Sex Not Listed (e.g. intersex)	0
Unknown/Declined to Answer	2
B) Current Gender Identity (Please mark only one)	
Male	40
Female	16
Transgender	0
Genderqueer	0
Questioning or Unsure of Gender Identity	0
Another Gender Identity Not Listed	0
Unknown/Declined to Answer	2

Disability Status (Please mark all that apply)**	
None	43
Yes. If yes, please specify (choose from list below):	
Difficulty Seeing	0
Difficulty hearing, or having speech	1
Mental Domain	4
Physical/Mobility Domain	3
Chronic Health Condition	0
Another disability not listed	0
Unknown/Decline to Answer	9
** There were two clients who had more than one disability.	

Veteran Status (Please mark only one choice)	
Yes	0
No	56
Unknown/Decline to Answer	2

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

REQUIRED STRATEGY: INCREASE ACCESS AND LINKAGE TO MENTAL HEALTH TREATMENT

a. Number of individuals with serious mental illness (SMI) who received a paper referral (i.e. referrals via phone do not apply) from your program to an ACBHCS mental health treatment program: We served a total of 58 unduplicated clients from July 1, 2018- June 30, 2019 and discharged 35 clients. During Q1 we had a total of 33 clients served and 10 clients were discharged from the program. Of the 10 clients who discharged in that quarter, 6 of the clients were given ACBHS mental health referrals. The remaining 4 clients either had private insurance, was unresponsive to engagement attempts, moved out of area or were already connected to multiple ACBHS mental health programs. In Q2, we served 38 clients and discharged 7 clients from the program. Out of the 7 clients discharged, 5 clients were given ACBHS mental health referrals. For the remaining 2 clients, one client moved out of county and the other client was not interested in services and was provided the phone number to ACCESS. In Q3, we served 35 clients and 18 clients were discharged from the program. Of the 18 clients discharged, 11 clients were given referrals to ACBHS. For the remaining 7 clients, either the client moved out of county, had private insurance, or were not interested in services and was provided with ACCESS phone number. During Q4, we had 6 clients discharged from the program. Out of the 6 clients discharged, 1 client was given a referral to ACBHCS mental health program, 1 client was given an out of-county referral since they relocated to Santa Clara County, and 3 clients were given ACCESS's phone number as these clients were not interested in services at this time and 1 client was already connected to several mental health providers and did not need additional referrals.

b. List type(s) of mental health treatment programs the individual was referred to: From July 1 2018- June 30, 2019, clients have been referred to various mental health programs with Alameda County for continuing care. The following is a list of all the programs that clients were referred to during this period: La Clinica, Pathway to
Wellness, West Coast Children's Center, Side by Side, Fred Finch, BACS, STARS, UCSF Children's Hospital Oakland, HUME Center, Oakland Children's Clinic, FERC, Seneca, and Berkeley Comprehensive Community Treatment. Pathways to Wellness is a program that provides medication support. West Coast Children's Center provided therapy and case management services. FERC is a program that provides emotional support and resources to the families of children, youth and adults with a mental health issue. All the other mental health programs listed above are programs that provide therapy, medication support, and case management services.

c. Number of individuals who were successfully referred and linked to an ACBHCS mental health treatment program (i.e. client has been seen at least once in person by a treatment provider): From July 1, 2018- June 30, 2019, we had a total of 12 clients who successfully linked to ACBH mental health treatment program where the client had attended at least one treatment session in person with the new ACBH provider. This data was gathered by using Clinician's Gateway, the electronic health record system linked to several providers within Alameda County. Even though clients are referred and linked to another community provider for continued care, our clients are sometimes challenged to attend these appointments due to transportation issues, motivation for continued treatment, unfamiliarity with new provider, and mental health symptoms experienced on the day of the appointment. However, it is important to note that in Q2 we implemented plan to accompany clients to their first appointment and as a result, we continuously increased in our success rate of linking clients to a new ACBH program. In Q1 we linked 16%, Q2 we linked 40%, Q3 we linked 82% and in Q4 we linked 100%.

d. Average duration in weeks of signs of untreated mental illness (per client self-report): From July 1, 2018-June 30, 2019, out of the 58 clients served we were able to accurately assess the onset of mental illness for 48 clients. The average duration of untreated mental health illness for these clients was 40 weeks.

e. Average time in weeks between when a paper referral was given to individual by your program and the individual's first in person appointment with a mental health treatment provider: During this fiscal year we were unable to track this consistently. Using Clinician's Gateway (county database) and CIRCE (our EHR system), we tracked the time the date a paper referral was made and the date of the client's first appointment with a new provider, which on average was about 3.01 weeks.

However, it is important to note that some of the challenges that we faced to connect clients to another mental health provider within a reasonable amount of time were difficulty engaging client with the new provider; difficulty scheduling an appointment within reasonable time; or client requiring higher level of care. Clients continued to receive services from the Early
Psychosis program until the warm-handoff was conducted.

f. Any additional information to report on? (Optional): N/A

Required Strategy: Improve Timely Access to Mental Health Services for Underserved Populations

a. Who is/are the underserved target population/s your program is serving (e.g. TAY, Southeast Asian, etc.)? We currently serve the TAY population and multiple minority communities which include African American, Latino, Southeast Asian and LGBTQI2-S.

b. Number of separate paper referrals to an ACBHCS PEI-funded program. (This can be a provider's internal ACBHCS PEI-funded prevention or early intervention program OR an external PEI-funded ACBHCS prevention or early intervention program): During this fiscal year, we had only one client who was referred to an ACBH PEI-funded program. All other clients were referred to other non-PEI funded ACBH mental health programs or out-of-county providers.

c. Number of individuals followed through on referral & engaged in an ACBHCS PEI-funded program: One client and their family members engaged in services offered by FERC, which was the referral we made to a PEI funded ACBH mental health program.

d. Average time in weeks between when a paper referral was given to individual by your program and the individual's first in person appointment with the ACBHCS PEI-funded provider. The initial referral was made to FERC four weeks before the first in-person appointment with the PEI- funded provider. It is important to note that our staff therapist had difficulty engaging the client's family with the new provider in addition to obtaining an appointment with this new provider. This client continued to receive services with the Early Psychosis program until the warm hand off was completed.to outpatient services with their private insurance and FERC to help support the family.

e. Describe ways your program encouraged access to services and follow-through on the above referrals: When making a referral, our staff discusses with the client which programs they are being referred to and how these services can help them to maintain stability. Our staff explores the client's willingness to continue treatment with the program they are being referred to as well as any other barriers to treatment. Our staff also engages the referral provider's staff to facilitate a successful warm-handoff.

f. Any additional information to report on (optional): N/A

OUTREACH. THIS SECTION IS *REQUIRED ONLY* FOR OUTREACH PROGRAMS. OTHERWISE, IT IS OPTIONAL

Number of potential responders: 24

List type of setting(s) in which the potential responders received outreach and the type(s) of potential responders engaged in each setting:

Type of Setting(s) (ex: school)	**Type(s) of Potential Responders** (ex: principals, teachers, parents, nurses)
Agencies- PHP & non-profits:	Mental health providers (i.e. counselors, SW, managers)
Fairmont Hospital	Mental health providers (i.e. counselors, SW, managers)
Girls Inc.	Mental health providers (i.e. counselors, SW, managers)
Berkeley Mental Health Dept.	Mental health providers (i.e. counselors, SW, managers)

NARRATIVE

a. Choose two of the above principles and describe how your program upholds or achieves those principles. Please speak to each principle separately and specifically describe how your program activities align with that corresponding principle.

Principle #1: Integrated Service Delivery. How does your program align with this principle? The Early Psychosis programs in Alameda County provide intensive services to help the client manage psychosis early, engage in treatment and improve functioning in the community. Not only do we offer mental health services, which include individual and family therapy and medication support, but we also have an Employment and Education Specialist (EES) who helps the client engage in school and/or the workforce, family support specialist and a peer support specialist. These two roles play a critical part of our team to provide the client and their family's emotional support and case management services from staff who have lived experience with mental health issues. Within EES services, the Employment and Education Specialist (EES) works directly with individuals to develop and implement employment and or education goals in-line with the IPS model and plans activities to decrease isolation and provide opportunities for clients to gain confidence in a variety of settings related to work and school goals. In addition, the Employment and Education Specialist helps clients through all phases of seeking employment and/or education placement including evaluation, planning, and resource development. Our therapists, EES, program manager, psychiatric nurse practitioner, family support specialist, and peer support specialist work collaboratively as a team and are introduced to the client as they wrap up the diagnostic assessment interviews to determine eligibility for early psychosis services. In addition, the staff also attends a weekly Team Collaboration meeting to discuss the needs of each client, identifying how each discipline can provide person-centered care within the client's community.

Principle #2: Cultural Competence. How does your program align with this principle? Our multidisciplinary team is culturally diverse and closely representative of the populations served, which are mostly African-American, Hispanic/Latino or Asian. The Early Psychosis staff work to maintain an attitude of cultural humility, learning from clients about their culture as they experience it, so that treatment can be tailored to include their values, beliefs, norms and traditions.

This process starts at intake and continues throughout the course of the therapeutic relationships with the client. In addition, the staff provides treatment in multiple languages and settings which include the office, clients' homes, schools, and in the community to help reduce the barriers to obtaining and engaging in treatment. Moreover, staff also participates in cultural competency trainings to maintain an up-to-date perspective on broader understandings of culture in all its forms (i.e. socio-economic, race, ethnicity, age, SOGIE, etc.). During this fiscal year, the Early

Psychosis programs provided direct services in Spanish and Gujarati in addition to English. To maintain these standards, our job descriptions list bilingual/bicultural experience as "required" for most key roles, and as "preferred" once those key positions are filled. We also list personal or family experience of mental health challenges as "highly desirable" in all our job descriptions.

b. Please tell us about the following…

i. Implementation Challenges: During most of the FY 2018-19, we operated with multiple unfilled staff positions which created challenges that resulted in smaller caseloads, less referrals and more reliance on other community resources. Due to these open positions (that included both management and line staff), as well as to transitioning out of previous contractual partnership (previous partner held the administrative oversight function for the program), we addressed pervasive quality assurance issues. Therefore, most of Q2 and Q3 focused on updating charts to meet Medi-Cal standards. During Q4, although the program was almost fully staffed, new staff onboarding and training impacted capacity to increase caseloads rapidly and we continued to rely on other community resources. Another challenge was having the need to slow down referrals in Q3 which impacted the flow of referrals in Q4 (which continued to be low). Moreover, during Q4, we also relocated to another site which required a new site certification.

ii. Successes: Despite the challenges we faced during FY 2018-19, we were able to maintain a census each quarter between 33- 38 clients. During this time, we launched the BEAM program component to provide treatment to clients experiencing symptoms of early psychosis and severe mood disorder. We also rebuilt our team and increased capacity to do research-validated diagnostic assessments and provide evidence-based treatment. We have strengthened the program by improving processes and streamlining systems from referral up to discharge. We also resumed attending the CQRT chart reviews at the ACBH and re-established our internal chart review process to ensure ongoing compliance with Medi-Cal standards. In Q4, we have successfully met the ACBH requirements for CQRT and have been released from attending the CQRT chart review meetings. Moreover, we have created standardized procedures and protocols for the referral, intake process, and onboarding new staff. As we have hired more staff, in efforts to obtain new referrals and educate the community about our services, we have reached out to multiple behavioral health providers and psychiatric hospitals. We are in the process of re-creating streamlined procedures and developing welcoming packets for new clients.

iii. Lessons Learned: Between Q1 and Q3, the long period with multiple vacant positions created challenges that resulted in low census, less referrals, and more reliance on community resources to ensure clients had access to necessary services. However, in Q4, the rapid staff increase, time needed to onboard new staff, and the effects of slowing down referrals in Q3, interfered with our ability to grow our census. The Felton Early Psychosis Programs – (re)MIND® and BEAM Alameda – will continue to address challenges related to Access to Linkage Strategy by continuing our direct outreach to treatment providers to inform them about our specialized services and re-build our referral network to facilitate engagement in outpatient services for individuals who do not meet criteria for early psychosis services, but who will, nonetheless, be engaged with us through the rigorous diagnostic assessment phase. We will also continue to strengthen our processes to ensure that transitioning clients are making at least one "successful linkage" to a community provider by lengthening warm-handoffs, including planning to attend their first appointment with the new provider.

iv. The Felton (re)MIND® and BEAM Alameda will also plan to improve access to services for underserved populations by maintaining a multidisciplinary team that is closely representative of our client population with most individuals identified as African-American and Hispanic/Latino. As we rebuild the team, we will actively recruit bilingual/bicultural individuals that are representative of the populations we serve.

v. Relevant Examples of Success/Impact (e.g. a client success story) Reminder: Please do not use real client names: Our first success story involves a high school student experiencing psychosis. Like many of the young people we serve, they had experienced multiple psychiatric hospitalizations when they enrolled in the Early Psychosis program in Alameda County. This young person's first hospitalization was due to being at-risk for self-harm and experiencing distressing auditory hallucinations and disorganized thinking and behavior. In addition to their increased psychiatric symptoms they also experienced other life stressors including the loss of their adoptive mother. Due to stressors and increased psychosis, they continued to experience multiple hospitalizations and needed support to regain stability in the community. Luckily, this young person had a supportive extended family where their adoptive grandmother and siblings sought services and helped them connect with specialized treatment. Over the course of several months this young person worked with our staff therapist and learned skills to identify triggers to symptoms and coping strategies to minimize delusions and thoughts of suicide. Through the course of treatment, they were able to gain insight into their symptoms, practice learned skills and coping strategies, and their symptoms stabilized. This young person will be graduating high school this year and will attend junior college in the fall.

The second success story involves a young person who had multiple psychiatric hospitalizations due to grave disability and suicide ideation. This young person also reported experiencing distressing auditory hallucinations, disorganized thinking, depressed mood and increased substance use. Over the course of 2 years of treatment, this young person worked with our staff therapist and learned skills to identify triggers to symptoms and coping strategies to minimize delusions and suicidal thoughts. This young person was able to gain insight into their illness, stopped using substances, practices learned skills and coping strategies and their symptoms stabilized. This young person has successfully graduated from our services, is currently working full time, is involved in advocacy work, and is planning to enroll in school in the fall.

The third success story involves a young person in high school. When this young person first arrived at our program, they were just hospitalized for aggression, command hallucinations, delusions, and bizarre behaviors. Some examples of this young person's symptoms were punching walls, verbal abuse towards family members, and cawing like an eagle. Through the course of treatment, the staff therapist was able to engage this young person by relating to their interests in Aztec and Mayan culture, such as the eagle from the Legend of Tenochtitlan. The young person and staff were able to create a plan that involved weekly psychotherapy and medication management which effectively decreased the symptoms. They were able to grow their interest in construction and enrolled in ROP classes. This young person is doing well, has successfully graduated from the program and will be graduating from high school this summer.

The last success story involves a young person experiencing a first onset of psychosis. This young person's symptoms revolved around hypercritical auditory hallucinations that impaired their ability to maintain a job. More specifically, the young person's auditory hallucinations were so intense they began yelling back at the voices while at work. In order to cope with the voices, this young person started smoking marijuana. However, this coping strategy only provided temporary relief as the voices quickly increased with greater intensity. This young person's marijuana use became a source of family turmoil as it jeopardized their housing situation. Fortunately, this young person was highly motivated to change.

The treatment team and this young person agreed to a harm reduction plan by reducing the frequency of substance use and trying a different strain of marijuana that would not exacerbate their psychosis symptoms. With the support of this young person's treatment team, this young person was able to obtain a job, speak at public venues about his recovery, complete his probation requirements, continue to have stable housing and graduate from our program.

ADDITIONAL INFORMATION

Please include the number of clients and/or contacts you estimate to serve in:

FY 19/20: 100 unduplicated clients.
FY 20/21: 100 unduplicated clients.

Please tell us about any changes you intend to make to your program over the next two fiscal years and explain your rationale for making these changes: In FY 2019-20 we plan to provide services to 15 years old individuals experiencing early signs and symptoms of psychosis or severe mood disorder, on a case-by-case basis. This will increase ACBH capacity to provide psychosis early intervention at a critical period closest to onset of disabling symptoms. We are also expanding our staff capacity and will increase our projected census from 80 to 100 unduplicated clients. In FY 2020-21 we plan to maintain our efforts to demonstrate the added value of psychosis early intervention to the system of care and achieve sustainability.

Prevention and Early Intervention Data Report FY 18/19

MHSA Program Number: PEI 3
Program Name: Mental Health for Older Adults, Geriatric Assessment & Response Team (GART)

GART is a mobile geriatric behavioral health team that provides support services to older adults ages 60 and above with serious behavioral health care needs. GART provides brief voluntary behavioral health care services with the aim of resolving immediate behavioral health needs.

General Information & Total Numbers Served

Total Numbers Served through PEI MHSA		
Number of unduplicated individuals your program serves who are **at-risk** of developing a mental health problem or serious mental illness (SMI)	**A**	89
Number of unduplicated individuals your program serves who show **early signs** of forming a more severe mental illness	**B**	24
umber of unduplicated individual family members served indirectly by your ogram:	**C**	
Grand TOTAL of unduplicated individuals served in the Quarter that you are number (D) should = A+B+C.]	**D**	89

DEMOGRAPHICS

Age Group (Unduplicated)	
Children/Youth (0-15)	
Transition Age Youth (16-25)	
Adult (26-59)	
Older Adult (60+)	98
Unknown/ Declined to Answer	

Race (Please mark only one choice) *If Hispanic or Latino, choose "Another race not listed."*	
American Indian or Alaska Native	
Asian	14
Black or African American	34
Native Hawaiian or other Pacific Islander	
White	43
More than one race	
Another race not listed	6
Unknown/ Declined to Answer	

Sexual Orientation (Please mark only one choice)	
Gay or Lesbian	8
Heterosexual or Straight	75
Bisexual	
Questioning or unsure of sexual orientation	
Queer	
Another sexual orientation not listed	
Unknown/Decline to Answer	20

Ethnicity /Cultural Heritage (Please mark only once choice)	
If Hispanic or Latino, please specify:	
Caribbean	
Central American	
Mexican/Mexican--American/Chicano	3
Puerto Rican	
South American	1
Another Hispanic/Latino ethnicity not listed	
Unknown/Declined to Answer	
If Non-Hispanic or Non-Latino, please specify:	
African	
African American	24
Asian Indian/South Asian	
Cambodian	
Chinese	12
Eastern European	
European	8
Filipino	1
Japanese	
Korean	
Middle Eastern	1
Vietnamese	
Other Non-Hispanic or Non-Latino ethnicity not listed	35
More than one ethnicity	
Unknown /Declined to Answer	

Primary Language (Please mark only one choice)	
English	83
Spanish	4
Farsi	
Cantonese	3
Mandarin	2
Other Chinese Dialects	4
Vietnamese	
Korean	
Tagalog	1
Other Filipino Dialect	
Japanese	
Laotian	
Cambodian	
Mien	
Hmong	
Samoan	
Thai	
Russian	
Polish	
German	
Italian	
Turkish	
Hebrew	
French	
Portuguese	
Armenian	
Arabic	1
Sign ASL	
Other primary language not listed	
Unknown/ Decline to Answer	

Gender Identity (Please mark both parts A & B)	
A) Assigned sex at birth: (Please mark only one choice)	
Male	25
Female	71
Other sex not listed (e.g. Intersex)	
Unknown/Decline to Answer	
B) Current Gender Identity: (Please mark only one choice)	
Male	22
Female	56
Transgender	
Genderqueer	
Questioning or Unsure of Gender Identity	
Another Gender Identity not listed	
Unknown/Decline to Answer	

Disability Status (Please mark all that apply)	
None	15
Yes. If yes, please specify (choose from list below):	
Difficulty Seeing	
Difficulty hearing, or having speech understood	2
Mental Domain	
Physical/Mobility Domain	33
Chronic Health Condition	3
Another disability not listed	
Unknown/Decline to Answer	44

Veteran Status (Please mark only one choice)	
Yes	5
No	58
Unknown/Decline to Answer	35

REQUIRED STRATEGY: INCREASE ACCESS AND LINKAGE TO MENTAL HEALTH TREATMENT

a. Number of individuals with serious mental illness (SMI) who received a paper referral (i.e. referrals via phone do not apply) from your program to an ACBHCS mental health treatment program: 100% of open cases (#23) receive a paper referral as part of their discharge process. When a client abandons services before a discharge summary can be written, GART clinicians send referral information through the mail as well as a client survey requesting feedback.

b. List type(s) of mental health treatment programs the individual was referred to: Outpatient psychotherapy, outpatient psychiatry, neuropsychology, inpatient geriatric & non-geriatric providers for additional assessment & treatment, day treatment programs and drop-in socialization and day rehabilitation centers,

field-based case management programs, peer-based support groups for older adults, friendly visitors, culturally responsive and language-specific mental health providers, recovery oriented substance abuse programs and providers, housing & homeless resources that cater to either older adults or individuals with mental health needs. Referrals to Alzheimer's Association are made for individuals (& their families) who have co-occurring dementia diagnoses.

c. Number of individuals who were successfully referred and linked to an ACBHCS mental health treatment program (i.e. client has been seen at least once in person by a treatment provider): Approx. 13 of the 24 opened cases were successfully referred and linked to ACBHCS mental health treatment programs. This number does not include clients who are still open and receiving services with GART and who may be referred/linked at point of discharge.

d. Average duration in weeks of signs of untreated mental illness (per client self-report): ranges from 1 month to 40+ years

e. Average time in weeks between when a paper referral was given to individual by your program and the individual's first in person appointment with a mental health treatment provider: 24 to 72 hours

f. Any additional information to report on? (Optional): Click here to enter text.

REQUIRED STRATEGY: IMPROVE TIMELY ACCESS TO MENTAL HEALTH SERVICES FOR UNDERSERVED POPULATIONS

a. Who is/are the underserved target population/s your program is serving (e.g. TAY, Southeast Asian, etc.)? Older Adults, individuals over 60 years of age. GART is the PEI program serving this population.

b. Number of separate paper referrals to an ACBHCS PEI-funded program. (This can be a provider's internal ACBHCS PEI-funded prevention or early intervention program OR an external PEI-funded ACBHCS prevention or early intervention program): None. GART does not refer to PEI programs.

c. Number of individuals followed through on referral & engaged in an ACBHCS PEI-funded program: None. GART does not refer to PEI programs.

d. Average time in weeks between when a paper referral was given to individual by your program and the individual's first in person appointment with the ACBHCS PEI-funded provider. None. GART does not refer to PEI programs.

e. Describe ways your program encouraged access to services and follow-through on the above referrals: GART is a hybrid early intervention (PEI) and ACBH specialty mental health program. Clinicians refer to non-PEI programs. Once services come to a close, GART clinicians develop a discharge plan with the client and engage their natural support systems. Together, they identify best-matched, continued care to fit a client's mental health needs. Clinicians will call providers to arrange appointments and, when appropriate and possible, accompany clients to those intake meetings. Prior to discharge, clinicians will follow up with clients and providers to confirm that a connection has been made and assist further if needed.

f. Any additional information to report on (optional): Click here to enter text.

NARRATIVE

a. Choose two of the above principles and describe how your program upholds or achieves those principles. Please speak to each principle separately and specifically describe how your program activities align with that corresponding principle.

Principle #1: Community Collaboration .How does your program align with this principle? GART clinicians have become regular presenters for the Alameda County Social Services Training and Consulting Team (TACT). They have provided valuable information about MHSA, the GART program and the mental health needs of older adults as part of an induction class for new public guardianship & conservator staff, APS & IHSS workers. In addition to these quarterly induction meetings, between August – October 2018, GART partnered with IHSS and met with 16 of their individual units to educate about identifying mental health issues during their assessment process and increase their ability to identify mental health needs for the older adults they serve. GART has become a resource for IHSS by providing consultation and ease of connecting client to best-matched mental health services to address their needs. GART regularly presents to Cal State East Bay nursing students and Meals on Wheels. Because the above mentioned programs serve older adults, it benefits our shared clients for us to have strong, coordinated relationships with one another. Additional outreach efforts have been made with providers such as Jay Mahler Recovery Center, John George Psychiatric Pavilion and Fairmont PHP day program to meet new staff and provide information about referrals and services that clients can expect of the GART program. The GART team participates in quarterly Multi-Disciplinary meetings with the Area Agency on Aging – this provides many opportunities to collaborate and partner with treatment, legal, medical providers.

Principle #2: Wellness and Recovery .How does your program align with this principle? The GART program utilizes a client-centered approach toward identifying short and long-term goals and designing personalized mental health services by using a collaborative treatment plan. Clinicians then accompany (vs. direct) the client during their wellness and recovery process – providing support & guidance when needed. Clinicians utilize W.R.A.P. – Wellness Recovery Action Plans to engage clients in an accessible wellness process that can be utilized well after treatment ends. The GART program makes use of a multi-disciplinary team approach which includes an RN who sees every client. Approaching mental health treatment in this way benefits the client because clinicians take a "whole person" perspective to assessment & treatment. Doing so is critical when working with an aging population due to the frequency of co-occurring medical conditions which frequently impact an individual's mental health. In spring 2019, GART supervisors participated in planning process with several community partners for Daybreak Adult Day Center's Trauma Informed Care Conference. Supervisor also served as a panel presenter representing the ways in which GART provides trauma informed services to older adults within the community.

b. Please tell us about the following…

i. Implementation Challenges: GART continues to identify ways to connect with isolated seniors in the community. In addition to the major IHSS outreach project we tackled during the first quarter, GART continues to reach out to primary care and nutritional providers - two entities that interface with seniors who are isolated or otherwise making little connection with mental health services. We continue to work toward more successful outcomes with primary care referrals. Clinicians have consistently found that while clients may agree to mental health services and GART outreach when introduced by their primary care provider, they decline when a clinician reaches out. We've attempted to mitigate this issue by working toward stronger relationships with primary care providers (PCP). We've also suggested that, when possible & appropriate, PCP coordinate with GART to meet client at doctor's office to facilitate referrals. GART moved Headquarters from Hayward to Oakland in May 2019. While it was hoped that the move will be seamless, mostly because the program is field-based vs. clinic-based, there has been a transition and adjustment. In addition, the division director and supervisor have been exploring the possibility of changing the program name & considering rebranding with the updates.

Successes: GART is a resource for the larger Alameda County Behavioral Health department and receives referrals and requests for consultation from all levels of treatment providers – including service team mangers, acute setting clinicians (e.g. John George Inpatient) and residential treatment providers (e.g. Woodroe Place, Morton Baker & Jay Mahler sub-acute facilities). This spring, University of California @ Berkeley invited supervisor to speak with intern students for information and recruiting purposes. There may be a possibility of a first-year intern joining the team in the fall. GART team continues to be invited to speak quarterly with Cal State East Bay RN students and Social Services new employees as part of their orientation/induction process. Division Director has asked the team to develop a training to provide for ACBH Crisis Team as part of its expansion of services.

ii. Lessons Learned: There are a considerable number of older adults who do not meet the criteria for Alameda County services because they are Medi-CARE only or because they have a large share of cost. This is a major barrier to treatment due to additional cost involved for seniors who want mental health treatment but who do not have full-scope Medi-CAL. There is an incredible amount of untreated (& frequently unreported) trauma within this population. Because we frequently share clients, coordinated care is critical across the multiple providers that serve this population (e.g. APS, primary care, IHSS). Although stigma and ambivalence regarding mental health treatment is very present amongst older adults, clients are more likely to engage in services within the comfort of their own home or chosen setting.

iii. Relevant Examples of Success/Impact (e.g. a client success story) Reminder: Please do not use real client names: 70 year old client with no prior history of mental illness was referred by primary care provider because she stopped attending medical appointments. In addition to chronic pain throughout her body, ct also complained of signs/symptoms consistent with major depressive disorder. During her intake appointment she described herself as feeling "dead inside". Initially she was agreeable to monthly check-ins with GART at her home. After meeting with the GART LCSW & RN twice, she shared information about extensive childhood physical & sexual trauma - as well as extensive substance abuse - that she had never revealed to her primary care providers. She agreed to meet weekly with the GART team and received individual therapy as well as brokerage services over a 6-8 month period of time. Services were extended for her due to her initial reluctance to engage in treatment as well as her need to transition thoughtfully to her new mental health providers upon discharge. This client's mood and level of daily functioning improved dramatically during this short period of time - she began looking into travel, social engagements and made progress in quitting her lifelong smoking habit. Upon discharge, this client was successfully linked to an ACBHCS contract provider.

Additional Information

Please include the number of clients and/or contacts you estimate to serve in:

FY 19/20: 25 - 35
FY 20/21: 30 - 40

Please tell us about any changes you intend to make to your program over the next two fiscal years and explain your rationale for making these changes: This Year GART has had nearly 500 individual contacts with the community, 180 of those were unduplicated. Of this number, the GART program has opened 45 who were eligible to receive specialty mental health services. Please see above (page 2) for details that explain the difference between these numbers and the ways in which GART serves the community both as a MHSA & Specialty Mental Health program. There are no plans to change the program over the next fiscal year. GART will continue to provide services in the hybrid manner described above (page 2) – serving clients who meet specialty mental health criteria and those who do not.

Prevention & Early Intervention PEI Data Report FY 18/19

MHSA Program Number: PEI 17A
Program Name: TAY Resource Centers- Youth Uprising

Youth Uprising (YU) provides peer group sessions, counseling for healing and health, case management and holistic wellness services to youth, ages 13-25 in an accessible community setting.

GENERAL INFORMATION & TOTAL NUMBERS SERVED

Total Numbers Served through PEI MHSA		
Number of unduplicated individuals your program serves who are **at-risk** of developing a mental health problem or serious mental illness (SMI)	**A**	335
Number of unduplicated individuals your program serves who show **early signs** of forming a more severe mental illness	**B**	5
Number of unduplicated individual family members served indirectly by your program:	**C**	17
Grand TOTAL of unduplicated individuals served in the Quarter that you are number (D) should = A+B+C.]	**D**	357

DEMOGRAPHICS

Age Group (Unduplicated)	
Children/Youth (0-15)	94
Transition Age Youth (16-25)	245
Adult (26-59)	
Older Adult (60+)	
Unknown/ Declined to Answer	1

Race (Please mark only one choice) *If Hispanic or Latino, choose "Another race not listed."*	
American Indian or Alaska Native	7
Asian	3
Black or African American	249
Native Hawaiian or other Pacific Islander	1
White	5
More than one race	
Another race not listed	44
Unknown/ Declined to Answer	31

Sexual Orientation (Please mark only one choice)	
Gay or Lesbian	5
Heterosexual or Straight	236
Bisexual	25
Questioning or unsure of sexual orientation	
Queer	5
Another sexual orientation not listed	3
Unknown/Decline to Answer	66

Ethnicity /Cultural Heritage (Please mark only once choice)	
If Hispanic or Latino, please specify:	
Caribbean	
Central American	
Mexican/Mexican--American/Chicano	8
Puerto Rican	
South American	1
Another Hispanic/Latino ethnicity not listed	50
Unknown/Declined to Answer	
If Non-Hispanic or Non-Latino, please specify:	
African	
African American	242
Asian Indian/South Asian	
Cambodian	
Chinese	
Eastern European	
European	3
Filipino	
Japanese	
Korean	
Middle Eastern	
Vietnamese	
Other Non-Hispanic or Non-Latino ethnicity not listed	12
More than one ethnicity	5
Unknown /Declined to Answer	19

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

Primary Language (Please mark only one choice)	
English	326
Spanish	3
Farsi	
Cantonese	
Mandarin	
Other Chinese Dialects	
Vietnamese	
Korean	
Tagalog	
Other Filipino Dialect	
Japanese	
Laotian	
Cambodian	
Mien	
Hmong	
Samoan	
Thai	
Russian	
Polish	
German	
Italian	
Turkish	
Hebrew	
French	
Portuguese	
Armenian	
Arabic	
Sign ASL	
Other primary language not	2
Unknown/ Decline to Answer	9

Gender Identity (Please mark both parts A & B)	
A) Assigned sex at birth: (Please mark only one	
Male	
Female	
Other sex not listed (e.g. Intersex)	
Unknown/Decline to Answer	
B) Current Gender Identity: (Please mark only one choice)	
Male	
Female	
Transgender	
Genderqueer	
Questioning or Unsure of Gender Identity	
Another Gender Identity not listed	
Unknown/Decline to Answer	

Disability Status (Please mark all that apply)	
None	262
Yes. If yes, please specify (choose from list below):	
Difficulty Seeing	
Difficulty hearing, or having speech	
Mental Domain	13
Physical/Mobility Domain	3
Chronic Health Condition	2
Another disability not listed	23
Unknown/Decline to Answer	37

Veteran Status (Please mark only one choice)	
Yes	1
No	337
Unknown/Decline to Answer	2

REQUIRED STRATEGY: INCREASE ACCESS AND LINKAGE TO MENTAL HEALTH TREATMENT

a. Number of individuals with serious mental illness (SMI) who received a paper referral (i.e. referrals via phone do not apply) from your program to an ACBHCS mental health treatment program: 3

b. List type(s) of mental health treatment programs the individual was referred to: Fred Finch, STARS,

c. Number of individuals who were successfully referred and linked to an ACBHCS mental health treatment program (i.e. client has been seen at least once in person by a treatment provider): 1

d. Average duration in weeks of signs of untreated mental illness (per client self-report): 52
e. Average time in weeks between when a paper referral was given to individual by your program and the individual's first in person appointment with a mental health treatment provider: 2

f. Any additional information to report on? (Optional): Click here to enter text.

Required Strategy: Improve Timely Access to Mental Health Services for Underserved Populations

a. Who is/are the underserved target population/s your program is serving (e.g. TAY, Southeast Asian, etc.)? TAY

b. Number of separate paper referrals to an ACBHCS PEI-funded program. (This can be a provider's internal ACBHCS PEI-funded prevention or early intervention program OR an external PEI-funded ACBHCS prevention or early intervention program): 81

c. Number of individuals followed through on referral & engaged in an ACBHCS PEI-funded program: 28

d. Average time in weeks between when a paper referral was given to individual by your program and the individual's first in person appointment with the ACBHCS PEI-funded provider. 2

e. Describe ways your program encouraged access to services and follow-through on the above referrals: We continue to encourage access by contacting within the week of initial paper referral and that initial visit the clinician travels to meet the client.

f. Any additional information to report on (optional): Click here to enter text.

Section 5. Outreach. This section is *__required only__* for Outreach programs. otherwise, it is optional

Measure	Annual Goal	Clients Served as of Quarter (1/2/3/Annual)
Number of referrals to supportive services	100	Q1:71/Q2:60/ Q3:59/ Q4/Annual: 257
Number of confirmed linkages to referrals	50	Q1:6/Q2:38/ Q3:52/ Q4/Annual: 155
Number of group series provided	16	Q1:4/ Q2:4/ Q3:4/ Q4/Annual:16
Clients receiving Intervention Visit	250	Q1:131 / Q2:372/ Q3: 117/ Q4/Annual:782
Clients receiving Individual Counseling	30	Q1:8/Q2:3/ Q3:8 New clients per quarter Q4/Annual:30
Clients receiving Group Counseling	N/A	Q1:147 /Q2:293/ Q3:188 Q4/Annual:812 members total visits
Clients receiving Holistic Healing Sessions	100	Q1:34/ Q2:75/ Q3:146/ Q4/Annual:425 total visits

- Group Themes for 2018-2019 : Self-Esteem, Self-Love, Empowerment, Healthy Relationships, Domestic Violence, Self-Reflection, Social Justice, Anti-bullying, Advocating for Self, Moving Beyond Fear, Emotional Balance, Emotional Intelligence Vulnerability, Trauma Triggers, Self-Care, and Coping Skills
- In the 2018-2019 we strengthened our Masters level clinical training model. This year 4 clinical interns (2 MSW from UC Berkeley, 1 MFTi from Holy Names University and 1 MFTi from CIIS) joined our clinical team to gain skills in the field and support our prevention model by offering direct clinical services to the members. Our intervention visit number has increase substantially due to having the additional clinical support and we are able to reach members that would not typically engage in traditional therapy.
- Many of the youth and community members are taking advantage of the YU Holistic services so our numbers have increased.
- We are strengthening our community collaboration and have a new clinical referral pipeline with EOYDC to support their youth with mental health services. We concluded our Leadership Training at EOYDC to decreased stigma around mental health services and increase access. We are now working with HHREC, another PEI funded program, to offer Healing through Art Workshops to our youth members and has an art exhibit up in the space.

NARRATIVE

a. Choose two of the above principles and describe how your program upholds or achieves those principles. Please speak to each principle separately and specifically describe how your program activities align with that corresponding principle.

Principle #1: Community Collaboration . How does your program align with this principle? Over the 2018-2019 fiscal year we have increased community collaboration tremendously. We have a partnership with EOYDC to decrease stigma around and increase access to mental health services. Reduced signs of trauma in TAY interns and increased awareness around triggers that impact their overall ability to function and build healthy relationships. Also, HHREC provided Health through Art workshops. This also expanded our community reach. We also have partnered with other PEI funded programs and community based organizations to have a more diverse delivery of mental health services. This has increased our ability to provide more holistic mental health services to a population that has challenges engaging in traditional therapy.

Principle #2: Integrated Service Delivery . How does your program align with this principle? We put specialized focus on strengthening our referral and collaboration process with our Arts & Expressions and Career & Education Departments in addition to other community based organizations such as EOYDC. Strengthening these partnerships allows the clinical team to better wrap around the entire youth and ensure that their overall needs are supported in a way that increase success and sustainability with supports such as employment, housing, and education services for TAY in a way that supports and prevents mental health challenges. This has also been proven to streamline access to mental health services for TAY.

b. Please tell us about the following…

i. Implementation Challenges: One challenge is connecting with the youth once a referral is received. Although we receive ample referrals capturing the TAY and registering them for therapeutic intervention often only takes 2 weeks however their follow through with the initial appointment is stretched due to typical TAY risk factors such as broken or no phone, moved, skipped class, etc.

ii. Successes: Strong partnerships with EOYDC and now HHREC (Health through Art), which increased our community collaboration and our ability to support more youth in the East Oakland neighborhoods. Creating a

graduate level clinical intern training program allows us to triage and provide mental health services to more TAY as well improve our visibility amongst other community stakeholders.

iii. Lessons Learned: Our highlight lesson learned this fiscal year is that partnership and multiple adult contact is important to sustaining the success and gains of our TAY client's.

iv. Relevant Examples of Success/Impact (e.g. a client success story) Reminder: Please do not use real client names: A 16 year old male was referred to YU with severe PTSD. He has been engaged in mental health services at YU for about 18 months. His PTSD symptoms impacted his ability to regulate his emotions in class and at home, leading to conflicts with his caregiver & teachers and impacting his overall academic success. During his time working with one of our clinicians he was able to obtain a 504 plan at his school. Because of this he was able to complete the school year and summer school with no incidents. He is now on track to graduating with his class. He was also able complete the summer job training at YU and was placed at a nearby café. Because of this success and his heightened confidence and ability to self-reflect he is now able to engage in family therapy to begin to repair his relationship with his caregiver.

Additional Information

Please include the number of clients and/or contacts you estimate to serve in:

FY 19/20: 300
FY 20/21: 300

Please tell us about any changes you intend to make to your program over the next two fiscal years and explain your rationale for making these changes: No changes anticipated.

Prevention and Early Intevention PEI Data Report FY 18/19

MHSA Program Number: PEI 17B
Program Name: TAY Resource Centers- REACH Ashland Youth Center

REACH serves youth ages 11 through 24 who live throughout Alameda County with a focus on the Ashland and unincorporated area. We help our members overcome the immediate and prevalent obstacles in their lives by cultivating their own strengths and promise. In the process, they develop resiliency and the skills they need to take positive action and thrive, even amidst ongoing personal trauma and social disadvantage.

GENERAL INFORMATION & TOTAL NUMBERS SERVED

Total Numbers Served through PEI MHSA		
Number of unduplicated individuals your program serves who are **at-risk**[1] of developing a mental health problem or serious mental illness (SMI)[2]	**A**	330
Number of unduplicated individuals your program serves who show **early signs** of forming a more severe mental illness	**B**	32
Number of unduplicated individual family members[3] served indirectly by your program:	**C**	231
Grand TOTAL of unduplicated individuals served in the Quarter that you are reporting about. [This number (D) should = A+B+C.]	**D**	593

List Number of Individuals Reached by each Activity (ex: who accessed website, social media hits, tabling/outreach events, eblasts, etc): 856; the community engagement events are an estimate for youth and adults who were reached. These numbers may be duplicated, with the exception of COST referrals.

Type of Activity (ex: accessed website)	**# of Individuals Reached**
COST Referrals	82
Non-clinical Health & Wellness groups and programs at REACH outside of COST	274
-Creative Writing, Gardening, Girls Group, Boys Group, Storytelling, Mindfulness, etc..	
Community Events (Cinco de Mayo, Holiday Lighting, etc.)	500

DEMOGRAPHICS

Age Group (Unduplicated)	
Children/Youth (0---15)	197
Transition Age Youth (16---25)	126
Adult (26---59)	0
Older Adult (60+)	0
Unknown/ Declined to Answer	7

Race (Please mark only one choice) *If Hispanic or Latino, choose "Another race not listed."*	
American Indian or Alaska Native	1
Asian	10
Black or African American	115
Native Hawaiian or other Pacific Islander	0
White	14
More than one race	34
Another race not listed	129
Unknown/ Declined to Answer	27

Sexual Orientation (Please mark only one choice)	
Gay or Lesbian	
Heterosexual or Straight	
Bisexual	
Questioning or unsure of sexual orientation	
Queer	
Another sexual orientation not listed	
Unknown/Decline to Answer	330

Ethnicity /Cultural Heritage (Please mark only once choice)	
If Hispanic or Latino, please specify:	
Caribbean	0
Central American	4
Mexican/Mexican-American/Chicano	87
Puerto Rican	1
South American	0
Another Hispanic/Latino ethnicity not listed	0
Unknown/Declined to Answer	31
If Non-Hispanic or Non-Latino, ple ase specify:	
African	42
African American	72
Asian Indian/South Asian	1
Cambodian	0
Chinese	4
Eastern European	1
European	13
Filipino	2
Japanese	0
Korean	0
Middle Eastern	0
Vietnamese	1
Other Non-Hispanic or Non-Latino ethnicity not listed	3
More than one ethnicity	34
Unknown /Declined to Answer	34

Primary Language (Please mark only one choice)	
English	154
Spanish	63
Farsi	0
Cantonese	0
Mandarin	0
Other Chinese Dialects	4
Vietnamese	0
Korean	0
Tagalog	0
Other Filipino Dialect	0
Japanese	0
Laotian	0
Cambodian	0
Mien	0
Hmong	0
Samoan	0
Thai	0
Russian	0
Polish	0
German	0
Italian	0
Turkish	0
Hebrew	0
French	0
Portuguese	0
Armenian	0
Arabic	0
Sign ASL	0
Other primary language not listed	2
Unknown/ Decline to Answer	107

Gender Identity (Please mark both parts A & B)	
A) Assigned sex at birth: (Please mark only one choice)	
Male	
Female	
Other sex not listed (e.g. Intersex)	
Unknown/Decline to Answer	330
B) Current Gender Identity: (Please mark only one choice)	
Male	122
Female	157
Transgender	0
Genderqueer	1
Questioning or Unsure of Gender Identity	0
Another Gender Identity not listed	0
Unknown/Decline to Answer	50

Disability Status (Please mark all that apply)	
None	
Yes. If yes, please specify (choose from list below):	
Difficulty Seeing	
Difficulty hearing, or having speech understood	
Mental Domain	
Physical/Mobility Domain	
Chronic Health Condition	
Another disability not listed	
Unknown/Decline to Answer	330

Veteran Status (Please mark only one choice)	
Yes	
No	
Unknown/Decline to Answer	330

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

REQUIRED STRATEGY: INCREASE ACCESS AND LINKAGE TO MENTAL HEALTH TREATMENT

a. Number of individuals with serious mental illness (SMI) who received a paper referral (i.e. referrals via phone do not apply) from your program to an ACBHCS mental health treatment program: 19

b. List type(s) of mental health treatment programs the individual was referred to: Individual therapy at REACH, Fuente
Wellness Clinic, Youth and Family Service Bureau, Eden Children Services, Fred Finch and Willow Rock Adolescent Center

c. Number of individuals who were successfully referred and linked to an ACBHCS mental health treatment program (i.e.
client has been seen at least once in person by a treatment provider): 15

d. Average duration in weeks of signs of untreated mental illness (per client self-report): 4

e. Average time in weeks between when a paper referral was given to individual by your program and the individual's first in person appointment with a mental health treatment provider: 2

REQUIRED STRATEGY: IMPROVE TIMELY ACCESS TO MENTAL HEALTH SERVICES FOR UNDERSERVED POPULATIONS

a. Who is/are the underserved target population/s your program is serving (e.g. TAY, Southeast Asian, etc.)? REACH serves youth who live in Alameda County ages 11-24 year and specifically youth who live and attend schools in the unincorporated areas of Ashland, Cherryland and San Lorenzo. REACH also serves youth who are involved in the justice system and foster care.

b. Number of separate paper referrals to an ACBHCS PEI-funded program. (This can be a provider's internal ACBHCS PEIfunded prevention or early intervention program OR an external PEI-funded ACBHCS prevention or early intervention program): 63

c. Number of individuals followed through on referral & engaged in an ACBHCS PEI-funded program: 38

d. Average time in weeks between when a paper referral was given to individual by your program and the individual's first in person appointment with the ACBHCS PEI-funded provider. 2

e. Describe ways your program encouraged access to services and follow-through on the above referrals: We connected youth services by conducting brief assessment of needs, vetting of the referral and assisting them to contact potential providers. We were also able to successfully connect youth to services by providing a warm "hand off" to program providers housed within REACH. We also contacted potential providers to inquire about service availability and turnaround time to youth to be contacted.

NARRATIVE

a. Choose two of the above principles and describe how your program upholds or achieves those principles. Please speak to each principle separately and specifically describe how your program activities align with that corresponding principle.

Principle #1: Client, Consumer, and Family Involvement How does your program align with this principle? We envision a vibrant community in which all youth thrive. We believe that when youth thrive our community also thrive. We infused youth voices in to our programming and have a youth led leadership group called Youth ERA (Empowered Residents of Ashland). We have started surveying families to inquire about level of interests in volunteering as well as workshops and topics that they would like to learn more about. REACH now has a Family Engagement team and sub committees dedicated to implement some of our family strategies. One of these sub committees is to prepare and design a family room where caregivers can utilize for meetings and workshops.

Principle #2: Integrated Service Delivery How does your program align with this principle? In the last year, we have

continued to build out our coordination of care service delivery model. We have a variety of programs provided by different organizations housed within REACH and understand the need for all of us to be coordinated and integrated as service providers.

b. Please tell us about the following…

i. Implementation Challenges: Transitional Age Youth services continues to be a challenge, no employment provider, lack of clarity around protocols and procedures, different levels of professional development, limited understanding of adolescent/youth development, and understanding of positive youth development model.

ii. Successes: Continue to have youth leadership group (Youth ERA), Successful 2nd annual Summer Camp at REACH, Coordination of Services Team (COST), youth engagement, and youth internship.

iii. Lessons Learned: Continue to build capacity and alignment with staff by increasing professional development trainings and opportunities. Increase outreach to the community including schools in the immediate areas and increase engagement with parents, caregivers, and families.

iv. Relevant Examples of Success/Impact (e.g. a client success story) Reminder: Please do not use real client names: This last fiscal year, the Youth Leadership Council now Youth ERA rebranded their name and became more involved with the Board of Supervisors Office and also helped with the successful implementation of a School Resource Officer (SRO) back in to REACH. Youth ERA met weekly to prepare questions and feedback for Supervisor Miley and his office in regard to the events which occurred the year prior when the proposal for the Alameda County Sheriff’s Office to become the lead operator of REACH.

ADDITIONAL INFORMATION

Please include the number of clients and/or contacts you estimate to serve in: FY 19/20: 350
FY 20/21: 350

Please tell us about any changes you intend to make to your program over the next two fiscal years and explain your rationale for making these changes: We hope to serve more youth with the addition of 2 clinicians from the Youth and Family Service Bureau Behavioral Health Unit as well as social work intern from Smith College. We also will be working on integrating our services better with our in-house partners as well as community partners.

Outreach for Increasing Recognition of Early Signs of Mental Illness PEI Data Report FY 18/19

MHSA Program Number: PEI 1C
Program Name: Early Childhood Mental Health Outreach and Consultation

Early Childhood Mental Health Consultation to teachers and directors in low-income preschool programs utilizing the Stands of Practice. Consultation with parents when additional support and linkages are indicated.

General Information & Total Numbers Served

Total Numbers Served through PEI MHSA		
Number of unduplicated individuals your program serves who are **at-risk** of developing a mental health problem or serious mental illness (SMI)	**A**	392
Number of unduplicated individuals your program serves who show **early signs** of forming a more severe mental illness	**B**	NA
Number of unduplicated individual family members served indirectly by your program:	**C**	21
Grand TOTAL of unduplicated individuals served in the Quarter that you are reporting about. [This number (D) should = A+B+C.]	**D**	413

DEMOGRAPHICS

Age Group (Unduplicated)	
Children/Youth (0-15)	291
Transition Age Youth (16-25)	10
Adult (26-59)	87
Older Adult (60+)	25

Race (Please mark only one choice) *If Hispanic or Latino, choose "Another race not listed"*	
American Indian or Alaska Native	1
Asian	79
Black or African American	144
Native Hawaiian or other Pacific Islander	2
White	57
More than one race	14
Another race not listed	116
Unknown/ Declined to Answer	

Sexual Orientation (Please mark only one choice)	
Gay or Lesbian	1
Heterosexual or Straight	201
Bisexual	
Questioning or unsure of sexual orientation	
Queer	
Another sexual orientation not listed	
Unknown/Decline to Answer	211

Ethnicity /Cultural Heritage (Please mark only once choice)	
If Hispanic or Latino, please specify:	
Caribbean	4
Central American	38
Mexican/Mexican--American/Chicano	110
Puerto Rican	1
South American	3
Another Hispanic/Latino ethnicity not listed	11
Unknown/Declined to Answer	
If Non-Hispanic or Non-Latino, please specify:	
African	50
African American	98
Asian Indian/South Asian	8
Cambodian	1
Chinese	27
Eastern European	
European	3
Filipino	4
Japanese	
Korean	
Middle Eastern	3
Vietnamese	17
Other Non-Hispanic or Non-Latino ethnicity not listed	
More than one ethnicity	16
Unknown /Declined to Answer	19

Primary Language (Please mark only one choice)	
English	141
Spanish	156
Farsi	
Cantonese	6
Mandarin	20
Other Chinese Dialects	
Vietnamese	17
Korean	
Tagalog	1
Other Filipino Dialect	1
Japanese	
Laotian	
Cambodian	
Mien	
Hmong	
Samoan	
Thai	
Russian	
Polish	
German	
Italian	
Turkish	
Hebrew	
French	1
Portuguese	
Armenian	
Arabic	5
Sign ASL	
Other primary language not listed	62
Unknown/ Decline to Answer	3

Gender Identity (Please mark both parts A & B)	
A) Assigned sex at birth: (Please mark only one choice)	
Male	130
Female	166
Other sex not listed (e.g. Intersex)	
Unknown/Decline to Answer	117
B) Current Gender Identity: (Please mark only one choice)	
Male	
Female	
Transgender	
Genderqueer	
Questioning or Unsure of Gender Identity	
Another Gender Identity not listed	
Unknown/Decline to Answer	413

Disability Status (Please mark all that apply)	
None	
Yes. If yes, please specify (choose from list below):	
Difficulty Seeing	
Difficulty hearing, or having speech understood	4
Mental Domain	2
Physical/Mobility Domain	
Chronic Health Condition	
Another disability not listed	
Unknown/Decline to Answer	407

Veteran Status (Please mark only one choice)	
Yes	
No	296
Unknown/Decline to Answer	117

REQUIRED STRATEGY: INCREASE ACCESS AND LINKAGE TO MENTAL HEALTH TREATMENT

a. Number of individuals with serious mental illness (SMI) who received a paper referral (i.e. referrals via phone do not apply) from your program to an ACBHCS mental health treatment program: Our clients are the preschool teachers, site directors, preschoolers, and their parents. Our work is supporting the teachers and parents in early detection of social –emotional difficulties, trauma, and, developmental delays. Our clients are not seriously mentally ill although some need support to prevent further deterioration or delay. 44 children, teachers, directors, and parents received referrals for treatment or assessment including to our own mental health services, to the OUSD Diagnostic Center for speech and language, Regional Services, and the Family Justice Center for domestic violence resources

b. List type(s) of mental health treatment programs the individual was referred to: our internal EPSDT mental health program, Access, and Kaiser

c. Number of individuals who were successfully referred and linked to an ACBHCS mental health treatment program (i.e. client has been seen at least once in person by a treatment provider): 10

d. Average duration in weeks of signs of untreated mental illness (per client self-report): N/A

e. Average time in weeks between when a paper referral was given to individual by your program and the individual's first in person appointment with a mental health treatment provider: 6 weeks

f. Any additional information to report on? (Optional): Click here to enter text.

REQUIRED STRATEGY: IMPROVE TIMELY ACCESS TO MENTAL HEALTH SERVICES FOR UNDERSERVED POPULATIONS

a. Who is/are the underserved target population/s your program is serving (e.g. TAY, Southeast Asian, etc.)? Primarily African American and Latin X children, and families. We serve children 0-5, and their caregivers

b. Number of separate paper referrals to an ACBHCS PEI-funded program. (This can be a provider's internal ACBHCS PEI-funded prevention or early intervention program OR an external PEI-funded ACBHCS prevention or early intervention program): N/A

c. Number of individuals followed through on referral & engaged in an ACBHCS PEI-funded program: N/A

d. Average time in weeks between when a paper referral was given to individual by your program and the individual's first in person appointment with the ACBHCS PEI-funded provider. N/A

e. Describe ways your program encouraged access to services and follow-through on the above referrals: We meet with parents and teachers when we see signs of challenging behaviors and trauma in children and give them strategies to help children remain in the classroom and make referrals when more intervention is needed. We also address trauma in teachers and parents and make referrals and linkages.

f. Any additional information to report on (optional): Click here to enter text.

Number of potential responders: Click here to enter text.

List type of setting(s) in which the potential responders received outreach and the type(s) of potential responders engaged in each setting:

Type of Setting(s) (ex: school, place of worship, clinic)	**Type(s) of Potential Responders** (ex: principals, teachers, parents, nurses)
preschools	Preschool teachers, site directors, parents, children

NARRATIVE

a. Choose two of the above principles and describe how your program upholds or achieves those principles. Please speak to each principle separately and specifically describe how your program activities align with that corresponding principle.

Principle #1: Cultural Competence . How does your program align with this principle? We have two mental health consultants for the program. One is African American and one is Latina witpanish being her first language. These two consultants represent the majority of our clients and have had extensive traing in cultural humility. Cultural and racial differences between consultants and clients are openly discussed to clarify and set a common understanding. Our consultants address how to have difficult conversations about race and culture with their individual supervisors and in group supervision.

Principle #2: Wellness and Recovery . How does your program align with this principle? The program utilizes action plans, which allows the clients to co-create with the mental health consultants the goals that they want to accomplish in order to enhance the quality of their care. This includes action plans for teachers, site directors, and plans for children which include parent and teacher feedback.

b. Please tell us about the following…

i. Implementation Challenges: The biggest challenge has been the continuous turnover of teachers and directors, resulting in ruptures in relationships, insecurity of children and parents, inconsistency, lack of follow through, and the need to redo action plans.

ii. Successes: Teachers have noticed a change in their ability to maintain children with challenging behaviors in their classroom. They also have better relationships with parents as well as their colleagues which allows them to better support the social-emotional needs of the children in their care

iii. Lessons Learned: We have learned that in spite of staff turnover and lack of substitute teachers, pushing for staff meetings is critical to address the overwhelm and chaos in the classrooms. Teachers are often too busy to meet but having insisted on this has made teachers and directors far more effective and increased their own sense of self-efficacy and skill to handle challenging children and families.

iv. Relevant Examples of Success/Impact (e.g. a client success story) Reminder: Please do not use real client names: A 3 year old child began at a child care center and was unable to transition each day. He clung to his mother and cried for extensive periods of time when she left in the morning and was unable to be comforted by his teachers. This child disrupted the circle time, was unable to follow directions, and was quite aggressive with his peers and teachers. He was unable to settle down at naptime and disrupted the other children. The teachers became quite frustrated and were each inconsistent in how they dealt with his challenging behaviors. Some scolded and shamed him and threatened to call his father who would be very punitive with him while others would not let him play outside or with the other children. The teachers blamed the mother for babying him and the mother blamed the teachers for treating her son badly. The teachers were beginning to talk about wanting him to leave the school. While meeting with the mother, the mental health consultant discovered that there was domestic violence in the home and that this child was afraid for his mother and afraid he would be hit next. The mental health consultant was able to help the teachers understand how the trauma he was experiencing was impacting his behavior and they were able to have more empathy and come together in implementing strategies to support him. The consultant gave the mother referrals for services including to our team for parent child trauma focused therapy. The consultant brought the mother and teachers together to come up with consistent strategies and a better understanding of the meaning of his behavior. Many children who end up with serious mental health issues begin their poor school and social adjustment when kicked out of preschools. This was a way of changing the trajectory for this child. It also helped to build the understanding and capacity of the preschool staff to support other children with challenging behaviors.

ADDITIONAL INFORMATION.

Please include the number of clients and/or contacts you estimate to serve in:

FY 19/20: This coming year we will be serving half as many classrooms due to a significant decrease in funding. We will serve 8 classrooms instead of 16 so we estimate about 205 clients

FY 20/21: same

Outreach for Increasing Recognition of Early Signs of Mental Illness PEI Data Report FY 18/19

MHSA Program Number: PEI 1D
Program Name: Unaccompanied Immigrant Youth Outreach (UIY)

The Unaccompanied Immigrant Youth Program (UIY) provides linguistically appropriate and culturally sensitive mental health services and interventions for youth who immigrated to the United States without the accompaniment of a parent. The program provides trauma-focused and family-oriented treatment to Unaccompanied Immigrant Youth Families through four Clinicians and two Case Managers who serve as a mobile unit providing services at schools and in the community throughout Alameda County.

GENERAL INFORMATION & TOTAL NUMBERS SERVED

Total Numbers Served through PEI MHSA		
Number of unduplicated individuals your program serves who are **at-risk** of developing a mental health problem or serious mental illness (SMI)	**A**	7,805
Number of unduplicated individuals your program serves who show **early signs** of forming a more severe mental illness	**B**	158
Number of unduplicated individual family members served indirectly by your program:	**C**	
Grand TOTAL of unduplicated individuals served in the Quarter that you are reporting about. [This number (D) should = A+B+C.]	**D**	7,963

REQUIRED STRATEGY: INCREASE ACCESS AND LINKAGE TO MENTAL HEALTH TREATMENT

a. Number of individuals with serious mental illness (SMI) who received a paper referral (i.e. referrals via phone do not apply) from your program to an ACBHCS mental health treatment program: FY 2018-19: 26 individuals; 4th Quarter Referrals only: 8

b. List type(s) of mental health treatment programs the individual was referred to: Specialty Mental Health Programs; EPSDT School Based and Outpatient Mental Health (Children's Hospital, Brighter Beginnings, CASA Del Sol, Family Paths and La Familia Counseling Services).

c. Number of individuals who were successfully referred and linked to an ACBHCS mental health treatment program (i.e. client has been seen at least once in person by a treatment provider): FY 2019-19: 12 individuals; 4th Quarter only: 5 individuals

d. Average duration in weeks of signs of untreated mental illness (per client self-report): FY 2018-19: 3.8 weeks; 4th Quarter: 1.4 weeks
e. Average time in weeks between when a paper referral was given to individual by your program and the individual's first in person appointment with a mental health treatment provider: FY 2018-19: 6.8 weeks; 4th Quarter: 3.4 weeks

f. Any additional information to report on? (Optional): No Additional Information on which to report.

REQUIRED STRATEGY: IMPROVE TIMELY ACCESS TO MENTAL HEALTH SERVICES FOR UNDERSERVED POPULATIONS

a. Who is/are the underserved target population/s your program is serving (e.g. TAY, Southeast Asian, etc.)? Unaccompanied Immigrant Youth and Children of Migrant Families - these are young people who are predominately monolingual Spanish speaking and are, by definition, newcomers to the United States.

b. Number of separate paper referrals to an ACBHCS PEI-funded program. (This can be a provider's internal ACBHCS PEI-funded prevention or early intervention program OR an external PEI-funded ACBHCS prevention or early intervention program): FY 2018-19: 148 referrals; 4th Quarter only: 26 referrals

c. Number of individuals followed through on referral & engaged in an ACBHCS PEI-funded program: FY 2018-19: 147 individuals; 4th Quarter only: 26 individuals

d. Average time in weeks between when a paper referral was given to individual by your program and the individual's first in person appointment with the ACBHCS PEI-funded provider. FY 2018-19: 1.27 days (or 0.18 weeks); 4th Quarter Only: 0.00, all new referrals for 4th Quarter were opened the same day.

e. Describe ways your program encouraged access to services and follow-through on the above referrals: Referrals generally come through COST (Coordination of Services Team) meetings that happen on a weekly basis at school sites. Additionally, some students self-refer after learning about the UIY program in a mental-health related workshop or group facilitated by a UIY Clinician or Case Manager. Others self-refer through a friend who received UIY services and reported having a positive experience in the program. If the student meets criteria for our program (i.e. they meet the CHSC definition of UIY or CMF and arrived in the US in the three (3) years prior to the proposed start of services) then the Clinician or Case Manager will follow-up with the referral by first doing outreach.

f. Any additional information to report on (optional): Outreach services consist of an in-person meeting to assess for any safety/risk factors, identify current symptomology, and explore their interest in receiving MH services. If the referral meets criteria, consents to treatment, and there is no wait list, the student's case will open to either case management or preventative counseling program.

OUTREACH. THIS SECTION IS *REQUIRED ONLY* FOR OUTREACH PROGRAMS. OTHERWISE, IT IS OPTIONAL

Number of potential responders: **3,000**

List type of setting(s) in which the potential responders received outreach and the type(s) of potential responders engaged in each setting:

Type of Setting(s) (ex: school, place of worship, clinic)	**Type(s) of Potential Responders** (ex: principals, teachers, parents, nurses)
Schools	Students, teachers, administrative staff, parents, other school-site service providers
Community	Community organizers, CBO staff
Other CBOs	Attorneys, legal staff

Narrative

a. Choose two of the above principles and describe how your program upholds or achieves those principles. Please speak to each principle separately and specifically describe how your program activities align with that corresponding principle.

Principle #1: Client, Consumer, and Family Involvement How does your program align with this principle? Clinicians and case managers involve the family depending on the unique circumstances of the client. In some cases, the client elects not to have the parent or family member engaged in treatment. If the client is UIY, there may not be a parent available to support the client and participate in services. Family involvement also depends on the unique family constellation and events precipitating the client's flight from persecution. Additionally, it can require significant outreach efforts to involve the family, due to work obligations and/or other stressors that may take precedence for the family around basic needs. In the case of CMF (Children of Migrant Families), there is a higher involvement of family collaboration, especially in the Tri-City area, where the percentage of CMF is higher. According to the UIY Care Team, they estimate involving the family in treatment for UIY approximately 30% of the time; for our case manager who serves the Tri-city area and mostly sees CMF, family involvement is dramatically higher: 70% of the time. In all cases, when the family is involved, the client's overall functioning tends to improve at a faster rate and linkages to care in the community are more seamless and effective in terms of outcome. Thus, utilizing family support is more holistic in the sense of addressing problems/needs within the context of the family system. This can assist in reunification and acculturation challenges, improve attunement to the needs of the client, which can all lead to better outcomes and success for UIY on a micro and macro level (i.e. higher rates of graduation, college readiness and success, etc.).

Principle #2: Community Collaboration How does your program align with this principle? UIY Care Team collaborate with a variety of CBOs (Community Based Organizations) and other NPOs (not-for-profit organizations) to meet the variety of needs for our clients. At the school sites, we assist with the referral process to the on-site health clinics to meet the medical/physical needs of our clients (such as Tiburcio Vasquez in the Hayward and Union City area). Many of these clinics offer a broad range of services such as vision, medical, and dental through their main offices. In some cases, mobile units come to the school site directly if the main offices are located off campus. In Union City, our case managers collaborate with the Family Resource Center, this site in particular offers a variety of resources to help meet basic needs of clients in the area of childcare, housing, and food resources. We also collaborate with the Family Specialist through EBAC (East Bay Agency Children); this individual supports all 3 districts of the Tri-Cities. Given our clients have ongoing legal needs due to their uncertain legal status, we refer to Centro Legal and International Institute of the Bay Area for legal aid. We collaborate with many other agencies to help meet the basic needs of our clients. We also refer to other programs within La Familia such as Social Service Center for Outpatient MH, EPSDT services for long-term therapy, and Cultura Y Bienestar (Culture and Wellness) for Outreach related to parenting support and other services. For academic needs, we may refer the client for tutoring within the school (if available) or Hayward Adult School; also, we make referrals to the Main Public Libraries or Eden Youth Family Center (in S. Hayward) for tutoring needs after-school. For recreational activity and team building, we refer UIY to Soccer without Borders which provides year-round programming free of cost in West Oakland, East Oakland, and Hayward. For housing needs and financial coaches, we collaborate with Spark Point. We also collaborate with some Faith-based Organizations, such as Eden Church and St. Joachim (starting this school year) in the Hayward area, and First Press Consortium (in Castro Valley) to help with housing needs, and donations for our clients (such as backpacks and toiletries).

In unique cases, we have collaborated with Faith-based Organizations to mobilize efforts in the community to help raise money to support an individual or family cope with a sudden death in the family, offset graduation costs, or help with legal costs in some cases.

Overall, it takes a village to help support UIY to navigate systems that affect their lives in powerful and impactful ways; after all they are newcomers and need assistance and support to coordinate care and create linkages within the school, family, and community.

b. Please tell us about the following…

i. Implementation Challenges: A salient implementation challenge to providing effective coordination of care for UIY has been the challenge of assisting students/clients to enroll in Medi-Cal. Currently there exist significant delays due to needing to have a guardian available to sign them up. Oftentimes a guardian is not available to accompany the student, due to not having the time (or luxury) to take time off from work. Another salient theme impeding this process is the fact that some students are living on their own and/or do not have a guardian that can assist in the process of enrollment, and because they are minors, they sometimes end up not enrolling altogether. Another barrier that can cause delays is when Medi-Cal enrollment has to go through a Newcomer Services Coordinator rather than the case manager directly – this step can slow down the referral process due to delays in follow-through, and trust issues as well due to not having a working alliance.

ii. Successes: The collaboration with various providers – at school sites and in the community – has allowed for broader support, for students/clients as well as staff. This highlights the value and success of outreach efforts and the benefits that come from fostering these relationships. Outreach services also broaden support for newcomers by having greater access to community resources such as food banks, coordinating care for legal aid or health coverage, and providing linkages to services such as housing referrals and addressing other basic needs.

iii. Lessons Learned: One lesson learned is to have case managers trained to assist in the enrollment process by scheduling an appointment with a Medi-Cal technician directly, rather than go through a middle person, or receive the necessary training to complete the applications themselves. More recently, the UIY Program Coordinator with The Center for Healthy Schools and Communities, Jasmine Gonzalez, is assisting with this process to help expedite the Med-iCal enrollment process.

i. Relevant Examples of Success/Impact (e.g. a client success story) Reminder: Please do not use real client names: Client B is an 18-year-old Guatemalan student at a high school in Alameda County. Client B was referred to UIY Care Team Therapist by a Coordination of Services Team (COST) that meets weekly at Client B's school site. Client B arrived to the U.S. in February of 2019 and reported having trouble with the grief and loss of being physically apart from her parents and three sisters. Client B shared about having to flee Guatemala due to receiving multiple death threats in her hometown. Client B recalled not having the opportunity to say goodbye to her family, and did not talk to them for over a month after her flight from persecution. Client B was able to connect with her maternal Uncle, who has been a fierce supporter of client, helping her navigate the manifold acculturation challenges that newcomers face upon arrival to the U.S. Client B struggled with concentration and attention difficulties in class, a normal trauma response due to being physically apart from her parents, three sisters, and school friends in her native country. Client B responded positively to mindfulness exercises and grounding techniques presented in therapy. Client B showed positive engagement with UIY therapist and consistency with her preventative counseling sessions. Client B reported improved functioning and symptom relief by listening to music and doing art (e.g., drawing and painting). Client B maintained good attendance at her high school and reported that she enjoys school, despite struggling with grief and loss issues and acculturation challenges. Notwithstanding having significant language barriers (e.g., Client B's native language is Mam, a Mayan indigenous language spoken in the western highlands of Guatemala) and gaps in her learning – Client B has received two certificates for Outstanding Achievement including making the Principal's Honor Roll and another for supporting other students in class (both teachers and students voted for this award). Furthermore, Client B's reunification with family living in the U.S. has been an additional protective factor in her healing process.

Additional Information

Please include the number of clients and/or contacts you estimate to serve in:

FY 19/20: Our anticipated goal for FY 19/20 is to provide 5,838 hours of service to 180 unduplicated UIY clients and 100 unduplicated family, school, and other community members.

FY 20/21: Our anticipated goal for FY 20/21 is to provide 5,838 hours of service to 180 unduplicated UIY clients and 100 unduplicated family, school, and other community members.

Please tell us about any changes you intend to make to your program over the next two fiscal years and explain your rationale for making these changes: We will continue to provide clinical training for staff in order to increase their therapeutic skills that will ultimately lead to better treatment outcomes. We will continue to evaluate UIY/CMF needs, develop relationships and build coalitions among staff and funders, and further staff development. These are our goals for the upcoming fiscal years; we expect to meet or exceed these goals given the high need for UIY services.

Outreach for Increasing Recognition of Early Signs of Mental Illness PEI Data Report FY 18/19

MHSA Program Number: PEI 1E
Program Name: School-Based Mental Health Outreach

The Outreach for School-Based Health Centers program is designed to bring awareness and information about how to identify early signs of mental illness in youth and connect those in need with the mental health services offered through the School-Based Health Centers. Efforts are targeted to reach potential responders and youth.

General Information & Total Numbers Served

Total Numbers Served through PEI MHSA		
Number of unduplicated individuals your program serves who are **at-risk** of developing a mental health problem or serious mental illness (SMI)	**A**	1,799
Number of unduplicated individuals your program serves who show **early signs** of forming a more severe mental illness	**B**	
Number of unduplicated individual family members served indirectly by your program:	**C**	
Grand TOTAL of unduplicated individuals served in the Quarter that you are reporting about. [This number (D) should = A+B+C.]	**D**	1,799

DEMOGRAPHICS

Age Group (Unduplicated)	
Children/Youth (0-15)	349
Transition Age Youth (16-25)	1,450
Adult (26-59)	327
Older Adult (60+)	
Unknown/ Declined to Answer	

Race (Please mark only one choice) *If Hispanic or Latino, choose "Another race not listed."*	
American Indian or Alaska Native	1
Asian	580
Black or African American	138
Native Hawaiian or other Pacific Islander	20
White	519
More than one race	200
Another race not listed	304
Unknown/ Declined to Answer	37

Sexual Orientation (Please mark only one choice)	
Gay or Lesbian	2
Heterosexual or Straight	
Bisexual	1
Questioning or unsure of sexual orientation	1
Queer	10
Another sexual orientation not listed	
Unknown/Decline to Answer	

Ethnicity /Cultural Heritage (Please mark only once choice)	
If Hispanic or Latino, please specify:	
Caribbean	
Central American	
Mexican/Mexican--American/Chicano	
Puerto Rican	
South American	
Another Hispanic/Latino ethnicity not listed	
Unknown/Declined to Answer	268
If Non-Hispanic or Non-Latino, please specify:	
African	
African American	
Asian Indian/South Asian	
Cambodian	
Chinese	
Eastern European	
European	
Filipino	58
Japanese	
Korean	
Middle Eastern	
Vietnamese	
Other Non-Hispanic or Non-Latino ethnicity not listed	
More than one ethnicity	200
Unknown /Declined to Answer	1,273

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

Primary Language (Please mark only one choice)	
English	
Spanish	
Farsi	
Cantonese	
Mandarin	
Other Chinese Dialects	
Vietnamese	
Korean	
Tagalog	
Other Filipino Dialect	
Japanese	
Laotian	
Cambodian	
Mien	
Hmong	
Samoan	
Thai	
Russian	
Polish	
German	
Italian	
Turkish	
Hebrew	
French	
Portuguese	
Armenian	
Arabic	
Sign ASL	
Other primary language not listed	
Unknown/ Decline to Answer	

Gender Identity	
A) Assigned sex at birth: (Please mark only one choice)	
Male	
Female	6
Other sex not listed (e.g. Intersex)	
Unknown/Decline to Answer	
B) Current Gender Identity: (Please mark only one choice)	
Male	7
Female	15
Transgender	2
Genderqueer	1
Questioning or Unsure of Gender Identity	
Another Gender Identity not listed	
Unknown/Decline to Answer	

Disability Status (Please mark all that apply)	
None	
Yes. If yes, please specify (choose from list below):	
Difficulty Seeing	
Difficulty hearing, or having speech understood	
Mental Domain	
Physical/Mobility Domain	
Chronic Health Condition	
Another disability not listed	
Unknown/Decline to Answer	

Veteran Status (Please mark only one choice)	
Yes	
No	
Unknown/Decline to Answer	

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

REQUIRED STRATEGY: IMPROVE TIMELY ACCESS TO MENTAL HEALTH SERVICES FOR UNDERSERVED POPULATIONS

a. Who is/are the underserved target population/s your program is serving (e.g. TAY, Southeast Asian, etc.)? LGBTQ community, first generation immigrant youth, youth identified as Black, Muslim, Latin-x, Asian, and Filipino. The Outreach for School-Based Health Centers program helps improve access to mental health services to a diverse population of youth across multiple schools that would otherwise be unaware and in some cases unable to obtain mental health support. By conducting outreach efforts on-campus, we provide information and resources directly to youth in a non-judgmental and easily accessible manner. By outreaching to school district and school site personnel who have relationships with all youth, our program was able to obtain referrals and connect with youth who would otherwise not seek services or support on their own.

b. Number of separate paper referrals to an ACBHCS PEI-funded program. (This can be a provider's internal ACBHCS PEI-funded prevention or early intervention program OR an external PEI-funded ACBHCS prevention or early intervention program): N/A

c. Number of individuals followed through on referral & engaged in an ACBHCS PEI-funded program: N/A

d. Average time in weeks between when a paper referral was given to individual by your program and the individual's first in person appointment with the ACBHCS PEI-funded provider. N/A

e. Describe ways your program encouraged access to services and follow-through on the above referrals: N/A

f. Any additional information to report on (optional):

OUTREACH. THIS SECTION IS *REQUIRED ONLY* FOR OUTREACH PROGRAMS. OTHERWISE, IT IS OPTIONAL.

Number of potential responders: 2,126

List type of setting(s) in which the potential responders received outreach and the type(s) of potential responders engaged in each setting:

Type of Setting(s)	Type(s) of Potential Responders (ex: principals, teachers, parents, nurses)
Suicide Awareness &	Students, Teachers, District Staff (367 youth & 17 adults)
District LGBTQ	Students, District Staff, Teachers, Community Members (6 youth & 4 adults)
City Collaborative	District Staff, Superintended, County Supervisor, City Staff, Program Directors of local
Class Presentations	Students & teachers (120 youth & 1 adult) + (85 youth & 6 adults)+(19youth & 6adults)
Middle School Chalk event	Students, teachers, district staff, administration (120 youth & 8 adults)
Teacher Packets about	Counselors, teachers, & administration (180 adults) *not counted
Youth Development	Students (27 youth)
Youth Confidence Event	Students, teacher (20 youth, 1 adult)
School Video about Mental	Students, school faculty (1700 youth, 78 adults) *not counted
Stress Awareness &	Students, teachers, counselors (55 youth, 15 adults)
District Behavioral Health	Director of Students Services, Program Managers (2 adults)
Gratitude Tabling Event	Students, teachers (30 youth, 5 adults)
Post-vention Support Mtg.	District Program Manager, School Psychologists, Counselors, Intervention Leads (20
BAPHR Presentation	Physicians (22 adults)
Mental Health	Counselors, School Psychologist, Intervention Lead (10 adults)
Family Night	Students, Teachers, Administration (50 youth, 55 adults)+ (45 & 36)

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

Health & Wellness Class	Students (11)
Teen Dating Violence	Students, teachers, administration, police department (633 youth & 40 adults)
Boys & Girls Club	Board Members (8)
Services Announcements	Students (2,880 youth) *not counted
Community/District Mtg.	Parents, District Staff, Community Members (18 adults)
Community Services Mtg.	Recent graduates, City Council members, community members (4 youth, 20 adults)
Mental Health Awrns Camp	Students, City Staff, Program Director of Girls Inc. (3 youth, 9 adults)
Mental Health Awrns	Students (180 youth)

NARRATIVE

a. Choose two of the above principles and describe how your program upholds or achieves those principles. Please speak to each principle separately and specifically describe how your program activities align with that corresponding principle.

Principle #1: Wellness and Recovery How does your program align with this principle? ? Though one of our main goals as an outreach program is to ensure those students most in need are aware and know how to access mental health services, we acknowledge that many of the students we interact with are not in crisis but are at risk of developing severe issues. Therefore we make strong efforts in each of our outreach efforts to promote wellness and resiliency. We want our consumers to hear about and acknowledge the importance of their own mental health and identify ways that they can maintain or when needed improve their wellbeing. For example, our Suicide Prevention Awareness Month activities have a significant focus on protective factors that the youth have the ability to partially control. At our tabling event this year, youth were encouraged and supported in identifying coping techniques that they already used in their lives as well as providing examples of alternatives. This was done through a bracelet making activity where various coping skills were assigned to different color beads. The youth were then able to make a bracelet for themselves that was designed to act as a reminder for them to use their coping skills when they were experiencing troubling emotions or thoughts.

Principle #2: Client, Consumer, and Family Involvement How does your program align with this principle? Youth are the primary consumers and clients for our outreach services and as such youth are encouraged and supported in having a voice in the content, planning, implementation, and evaluation of all of our outreach efforts. We do this at multiple levels and with diverse range of students who are interacting with our program. At each of the health centers we have created an advisory board that is comprised of youth representatives from the school. This diverse group of students plays an essential role in helping ensure that our outreach efforts are properly designed to meet our target audience. They assist with the planning on how to convey the information in a manner that will be received by youth. At large events, the youth actually assist in the tabling, encouraging their peers to interact with the information that is being provided. Lastly, the youth advisory board meets after a large event to celebrate the achievements and brainstorm how to address any challenges that arose. Also, every youth that interacts with our outreach efforts is invited to take an anonymous evaluation survey that provides our program with valuable information regarding the consumers experience with our outreach efforts.

b. Please tell us about the following…

i. Implementation Challenges: Stress Management – Trying to provide additional support at a very stressful time had a competing message to youth. We made multiple attempts in our outreach and warm handoffs from school personnel and though successful for those students that attended, we had lower numbers that we had originally anticipated given our youth advisory board and our own clients' verbalization that they and other students would benefit from having events focused on stress management.

ii. Successes: Through our 3 day Stress Awareness & Management series, we successfully provided youth with space to be able to decompress and prioritize their mental health at a peak time of stress with finals, college applications, and the holidays approaching. Students who participated in the series obtained peer support, knowledge about mental health resources on-campus, and took away both physical objects and strategies to be able to manage stress. Youth also learned how to take an inventory of their own stress level and identify what internal resources they can access on their own and when to seek mental health support both for themselves and their peers.

iii. Lessons Learned: A lesson we learned from our Stress Management series was that though the concept of providing a time and space for stress management was highly desired by youth, actually stepping away from their stress to take time for themselves was actually harder for them than we all anticipated. The belief was that by providing students with strategies to take care of their own mental health the week before finals would allow them to enter finals in a better space, however many students were already too stressed at that time. We will explore doing a similar event at the end of next semester and will start it a week earlier.

iv. Relevant Examples of Success/Impact (e.g. a client success story) Reminder: Please do not use real client names: Though our efforts for the Stress Management were geared towards upper class students in the high school dealing with Finals and College Applications, we had a number of new middle schoolers come to the events. This provided us with the opportunity to develop relationships with youth who had not interacted with our Health Center. The Stress Management event led to one of the middle school students entering into individual therapy.

Evaluation Plan Update

a. Please describe, in 1-2 sentences, your effort to collect feedback from program participants (method used). Please include the timeframes of when you survey clients. We created an anonymous Google Form that youth have the option of completing through our tablets when they engage in our events. We only collect data survey during the events to ensure the data is from youth who have actually participated.

b. Describe the tool (i.e. MHSIP or another survey) used to collect data. The Google Form is a 5 question survey that was created by staff with input from our Youth Advisory Boards.

c. Summarize the results if any. 87.5% of the youth who have taken the survey, responded that they had learned at least one thing about Suicide Prevention during our events. 95.2% of youth responded “Yes” to knowing at least one person/place that they can go to for help on campus. 62% of youth responded “Yes” to knowing they can access Mental Health Support at the SBHCs. 100% of the youth responded “Yes” to enjoying the events.

d. What was learned from the participant feedback (**1-2 key points**)?The most significant point to us is that 75% of the youth were knowledgeable about obtaining mental health support at the SBHC. This is a number we hope to continue to grow throughout our efforts.

e. Describe how the findings were reviewed by staff. As a Google Form, the Program Director was able to bring up the results as a Summary with graphs. This was presented during a Staff Meeting. At the staff meeting staff highlighted trends, celebrated success, and focused discussion on comments that showed needs for improvement.

f. What programmatic change(s) were or will be adopted as a result of the findings? When will changes be made and how will the changes impact programming? A change we had been discussing for a long time, but did not have the data to support, was that we need to unify the branding of the SBHC. Anecdotally, students have shared that there is some confusion about the School Based Health Center being a part of the school and not a program of Alameda Family Services. We are now being mindful of putting our logo on all of our paperwork, flyers, and posters. We also are making sure to visibly note that any of the classroom presentations or lunch time tabling events are provided the School Based Health Center. We hope that this will provide clarification

to youth and staff and eventually lead to more students both being knowledgeable about where to obtain services and seeking them out when in need.

g. What issues or challenges with the Evaluation Plan are you having? What technical assistance do you need? No need.

ADDITIONAL INFORMATION

Please include the number of clients and/or contacts you estimate to serve in:

FY 19/20: 1,850
FY 20/21: 1,900

Please tell us about any changes you intend to make to your program over the next two fiscal years and explain your rationale for making these changes: We would like to explore the potential of providing outreach on a smaller scale to the middle schools. Anecdotally, youth report experiencing mental health needs in middle school, but not necessarily having the resources or autonomy to access services. With additional funding, we believe we may be able to provide outreach & awareness about relevant mental health issues and even refer youth to resources within the community.

Outreach for Increasing Recognition of Early Signs of Mental Illness PEI Data Report FY 18/19

MHSA Program Number: PEI 1F
Program Name: Community-Based Mental Health Outreach and Consultation

EBAC's Fremont Healthy Start Program engages, encourages, and trains potential community responders, primarily family members of youth and children but also school staff and community members, about ways to recognize and respond to early signs of mental illness.

GENERAL INFORMATION & TOTAL NUMBERS SERVED

Total Numbers Served through PEI MHSA		
Number of unduplicated individuals your program serves who are **at-risk** of developing a mental health problem or serious mental illness (SMI)	**A**	1,053
Number of unduplicated individuals your program serves who show **early signs** of forming a more severe mental illness	**B**	92
Number of unduplicated individual family members served indirectly by your program:	**C**	2,526
Grand TOTAL of unduplicated individuals served in the Quarter that you are reporting about. [This number (D) should = A+B+C.]	**D**	3,672

DEMOGRAPHICS

Age Group (Unduplicated)	
Children/Youth (0-15)	36
Transition Age Youth (16-25)	103
Adult (26-59)	623
Older Adult (60+)	383
Unknown/ Declined to Answer	0

Race (Please mark only one choice) *If Hispanic or Latino, choose "Another race not listed."*	
American Indian or Alaska Native	0
Asian	662
Black or African American	22
Native Hawaiian or other Pacific Islander	15
White	63
More than one race	4
Another race not listed	315
Unknown/ Declined to Answer	61

Sexual Orientation (Please mark only one choice)	
Gay or Lesbian	
Heterosexual or Straight	37
Bisexual	
Questioning or unsure of sexual orientation	
Queer	
Another sexual orientation not listed	
Unknown/Decline to Answer	298

Ethnicity /Cultural Heritage (Please mark only once choice)	
If Hispanic or Latino, please specify:	
Caribbean	1
Central American	13
Mexican/Mexican--American/Chicano	283
Puerto Rican	0
South American	12
Another Hispanic/Latino ethnicity not listed	85
Unknown/Declined to Answer	5
If Non-Hispanic or Non-Latino, please specify:	
African	0
African American	22
Asian Indian/South Asian	120
Cambodian	5
Chinese	200
Eastern European	0
European	0
Filipino	39
Japanese	0
Korean	105
Middle Eastern	79
Vietnamese	32
Other Non-Hispanic or Non-Latino ethnicity not listed	82
More than one ethnicity	0
Unknown /Declined to Answer	62

Primary Language (Please mark only one choice)	
English	335
Spanish	347
Farsi	12
Cantonese	43
Mandarin	128
Other Chinese Dialects	25
Vietnamese	21
Korean	81
Tagalog	0
Other Filipino Dialect	7
Japanese	0
Laotian	0
Cambodian	5
Mien	0
Hmong	0
Samoan	0
Thai	0
Russian	0
Polish	0
German	0
Italian	0
Turkish	0
Hebrew	0
French	0
Portuguese	0
Armenian	0
Arabic	0
Sign ASL	0
Other primary language not listed	71
Unknown/ Decline to Answer	70

Gender Identity (Please mark both parts A & B)	
A) Assigned sex at birth: (Please mark only one choice)	
Male	362
Female	790
Other sex not listed (e.g. Intersex)	0
Unknown/Decline to Answer	0
B) Current Gender Identity: (Please mark only one choice)	
Male	362
Female	790
Transgender	
Genderqueer	
Questioning or Unsure of Gender Identity	
Another Gender Identity not listed	
Unknown/Decline to Answer	

Disability Status (Please mark all that apply)	
None	678
Yes. If yes, please specify (choose from list below):	
Difficulty Seeing	4
Difficulty hearing, or having speech understood	5
Mental Domain	23
Physical/Mobility Domain	20
Chronic Health Condition	31
Another disability not listed	7
Unknown/Decline to Answer	191

Veteran Status (Please mark only one choice)	
Yes	0
No	1145
Unknown/Decline to Answer	0

OUTREACH. THIS SECTION IS *REQUIRED ONLY* FOR OUTREACH PROGRAMS. OTHERWISE, IT IS OPTIONAL.

Number of potential responders: 3,672

List type of setting(s) in which the potential responders received outreach and the type(s) of potential responders engaged in each setting:

Type of Setting(s) (ex: school, place of worship, clinic)	**Type(s) of Potential Responders** (ex: principals, teachers, parents, nurses)

Fremont Healthy Start Program Office	Parents, caregivers, general community members
Fremont Family Resource Center Welcome	Parents, caregivers, general community members
School	School staff, teachers, parents, caregivers
Client Homes	Parents, caregivers, general community members

NARRATIVE

a. Choose two of the above principles and describe how your program upholds or achieves those principles. Please speak to each principle separately and specifically describe how your program activities align with that corresponding principle.

Principle #1: Client, Consumer, and Family Involvement How does your program align with this principle? Trauma involves a loss of power and control that makes those impacted by trauma feel helpless. By giving real opportunities for parents to provide their voice and choices, they will feel empowered and can promote their own wellness. Creating and developing leadership and growth opportunities for families is a core value of our Family Resource Centers (FRC). To this end, EBAC has trained 10 parent leaders as Family Health Advocates (FHAs) to provide culturally appropriate outreach and education regarding health insurance and public benefits options to other parents. Peer to peer outreach and education has been shown to be very effective strategy when working with other parents. FHAs receive training through Alameda County and EBAC to prescreen for Medi-Cal, CalFresh, HealthPAC, and Covered California enrollment applications, including ongoing professional development throughout the school year to support their leadership development. They also receive training to conduct outreach and promote the services offered through our center within their communities. They participate in trainings and perform enrollment and outreach tasks within their communities for approximately 10 hours per month. Additionally, the FRC launched its FRC Advisory Team (FRCAT) this spring, which included one FHA. FRCAT will work on different projects and provide recommendations. FRCAT has worked on updating the Universal Intake to ensure it is family and user friendly. A program coversheet for the Intake was also developed to assist in explaining to families what to expect in the process, our values and who to contact if they have questions. An intake tip guide additionally was created with instructions on how to conduct a universal intake in a trauma-informed way and how staff can apply these techniques as they conduct intakes. It was important to include parent voice in this process to ensure that our forms and process are family friendly. We are working on a scoring guide next to help prioritize family need. It is our desire in the future to also have a parent representative on the EBAC Board, as well as to form a Parent Advisory Board.

Principle #2: Wellness and Recovery How does your program align with this principle? As part of EBAC's ongoing process to become trauma-informed, we are intentional to make improvements towards achieving this goal. For example, we have trained staff in Trauma Informed Principles, created welcoming spaces, and have implemented Trauma Informed System Principles in programming and trauma informed case management. Our objective is for staff to embody these principles by reflecting these principles in their daily work and brainstorming ways that the Family Resource Centers can develop resources to support families in this area. Some of the resources will be developed by staff while others resources will be developed in FRCAT. Examples of these resources include: developing a cultural family wellness power point that will be used for training other staff, enrollment process flow chart, mindfulness activities, and wellness resources for parents for children. Diverse social and cultural groups may experience and react to trauma differently. Our goal is to respond to them sensitively to make each other feel understood and to enhance wellness. As part of these efforts, the FRC offices are being assessed for being inclusive, trauma-informed, and family friendly. Our guiding vision is to create a calming experience as staff and families navigate the office space. Given the high volume of traffic and sometimes chaotic nature of the work, it is important ensure a grounded and tranquil physical environment. Fremont Healthy Start was the first center to pilot this process. It focused on revamping its lobby and staff lunch room and created a new Wellness Space. The Wellness Space provides a calming area for families and staff with a tranquil sitting area, nature mural, and warm lighting. We worked with our Wellness Consultant to assess the space and develop a space design. The plan was further discussed with staff and adjustments were made to customize the space. Response from staff and clients has been positive. It has changed the way they interact with this space. It has also inspired some

to look at ways of incorporating calming spaces in their homes.

b. Please tell us about the following…

i. Implementation Challenges: An ongoing challenge continues to be the lack of mental health resources in the community that are culturally and linguistically appropriate. While EBAC staff is successful in helping to de-stigmatize mental health challenges and getting clients to feel comfortable talking about them, it is challenging when there are not enough organizations to which clients can be referred. Clients express a desire to be referred for counseling services, but there are no services available in their language. Staff continues to provide information on mental health and brief education to build trust. The majority of our clients do not speak English, and this creates barriers to accessing services. This creates further challenges for our staff in providing outreach and education. The lack of insurance options for undocumented clients is also a challenge. With fears of public charge and the current immigration climate, some clients are reluctant to receive social services. Immigration fears has created a lot of emotional turbulence in some families. In particular, staff have reported the impact on young people. Hearing about ICE raids, the caravan of people coming over, children being separated from their parents, makes young people feel afraid and some put blame on parents for bringing them here. There is fear of losing work permits or the ability to renew. All of this is detrimental to the mental health of young people and immigrant families. A final challenge has been that wellness information for young children is not always received well by parents. For example, one staff referred a family to the Infant Toddler Program and a parent responded, "How do you know there is an issue with my child - he is so young?" Staff are continuing to provide education in this area.

ii. Successes: Our staff are breaking stigmas around accessing mental health services and offering support to those who might not otherwise have it. Because of staff's own experiences with mental health challenges, they are able to connect with families. They help validate and normalize experiences. They are seen as a friendly face in the community that has access to many resources; clients have shared that it is for this reason that they came to the Family Resource Center for help. While these families come to the Center seeking assistance with basic needs rather than mental health services, staff is able to begin having the sometimes difficult conversations about mental health while connecting them to resources. Since shame related to accessing mental health services is strong in many cultures, it is advantageous to our program that clients do not view EBAC's Family Resource Center as a mental health service provider. In this way, families who come to our center know that they do not need to worry that their community will know and thus they feel free to have those confidential conversations with staff that they trust. Through these efforts, we have succeeded in having many of these resistant clients return to express interest and seek referral for services. Another success is the continued effort by FHS Family Resource Specialists to build upon partnerships with community agencies and attend mental health trainings to enhance their ability to assist the vulnerable populations we serve. Staff works closely with the 21 agencies at the Fremont Family Resource Center (FFRC), working with the Center's case managers, Youth and Family Services, Alameda County Social Services, and Tri-City Health Center, among many others. EBAC has a contract with the FFRC to staff the information desk at the Welcome Center and provide one-on-one application assistance to walk-in clients. This contract has been in effect for the last 20 years, and our staff's experience over these years has greatly increased staff's knowledge of service eligibility requirements of each of the 21 agencies housed at the FFRC. We further learned that asking about their child's behavioral health first is an effective way to begin a conversation about mental health issues in the family. Also, parents are more open to seeking help if their struggles are not framed as "mental health issues." Staff additionally participated in several mental health and wellness trainings to support and reinforce their outreach work. These include: Mental Health First Aid, Vicarious Resilience, The Practice of Mindfulness and De-Escalation Techniques, Implicit Bias, and Trauma Informed Care. Staff reported that all the trainings were helpful to their work. One staff participated in NAMI's Family-to-Family program, which is a 12 class education program for family members of adults living with mental illness. In this program the term family is viewed from a broad perspective to include parents, siblings, spouses, adult sons and daughters, partners and significant others. Participants learn about the normative stages of our emotional reactions to the trauma of mental illness; our belief system and principles; understanding mood disorders; characteristic features of

psychotic illnesses; brain science; research on functional and structural brain abnormalities in the major mental illnesses; genetic revolution in biological psychiatry; genetic transmission of mental illnesses; Problem Solving Skills; Medication Review; Early warning signs of relapses; and Self Care. Further, the Mental Health Screening tool continues to be very useful in helping to start the conversation on mental health, which can be very difficult for some families. Finally, we have found that in the moment strategies, such as breathing exercises, relaxation methods, and coloring mandalas, can help clients ground themselves if they are feeling triggered.

i. Lessons Learned: Staff are sharing supportive resources and referrals and creating conversations to shift the narrative around what support can look like, what therapy can look like, and how accessible and relatable it can be. Helping families understand what they can expect opens up a conversation about therapy and how it can be a helpful resource. We are also empowering families to access support within themselves, to recognize their own ability to grow, and to realize that they are their own expert and healer, whether or not they have access to mental health services. This is an important service in helping families who may not want or are not ready to receive mental health services in a standard setting. It helps to reframe that everyone needs a little help sometimes and that it is okay. It helps to have an understanding of why we do the things we do. That understanding alone can positively impact families with the hope of leading to more healing conversations with a trained professional. We deepened our understanding of the importance of community and connection in healing. We have learned the incredible empowerment that comes with choosing to seek these resources and insights and choosing a new path. We understand the impact it has on people's lives. Our staff feel fortunate to be able to witness it. Our goal is for our work to be destigmatizing and to provide access, which often keeps families from seeking services, and convey that services do not have to be scary, isolating or a secret. In our role, we have found a space to provide education and support beyond the walls of mental health programs and bring connection, tools, resources, and support too many. Staff has learned that creating wellness areas for people seeking supportive services helps to minimize their anxiety and positively impacts mental health. In response, and as an effort to strengthen our trauma-informed practices, staff from Fremont Healthy Start consulted with EBAC's Wellness Consultant to make changes to the program location's lobby area and breakroom and create a wellness area for clients and staff. Improvements included furniture placement changes, new plants, softer lighting, and the addition of social justice and wellness posters. Staff has deepened their understanding that being trauma-informed means that appointments may not be kept, answers may not be given, stories may not be shared, and papers may be forgotten due to the experience lived. There are ways in speaking to a client and really hearing them or looking at body language that are telltale signs of trauma. It is okay to stop doing paperwork when you see that the client has been triggered by something during the encounter, it is okay to address issues and allow clients to vent if that is what they want. It is important that staff are creating a safe place for families. Reaching out for services can be humiliating and difficult to some with a high sense of pride. Staff has an understanding that our clients are hurt but they do not treat them with pity. Being able to work with them in a way that gives them power helps with how they see the help given. Staff continue breaking taboos and preconceived notions about mental illness. Staff found that the mental health questionnaire triggers emotional responses in some people and that they need to be prepared for mindfulness or deep breathing activities. Mujeres Unidas has been a good resource for some of the Latina clients as they have support groups and a crisis hotline. One staff will be trained soon by SAVE for Project Light which will enable her to run support groups for women living in domestic violence situations.

ii. Relevant Examples of Success/Impact (e.g. a client success story) Reminder: Please do not use real client names: Story #1 An immigrant family of four was struggling with the father's recent disability, which was impacting their financial situation. The mother visited EBAC's Family Resource Center for assistance with a CalFRESH application and was given a mental health screening. She revealed her family's situation and shared that there was a great deal of conflict in the house hold, resulting in her desire to separate from her husband. She shared that her children were also frustrated. Staff validated and normalized her feelings. Even though it was her first time meeting with our staff person, she felt comfortable talking to her and opening up about her painful situation. Our staff person was able to refer her for mental health services so that she is able to talk to someone about this transition in her family. Story #2: A mother and her teen daughter came

in for Medi-Cal application assistance. There was obvious friction between the two. The mother had been struggling with depression making it difficult to get out of bed. The teen disclosed self-esteem issues from having undocumented parents and having an inferiority complex and resentment towards her parents for putting her in this situation. The daughter made a comment about her mother being weak. Staff explained that the mind gets sick just like the body does. If we get sick we see a doctor; it is the same for the mind. This reframing helped to shift the teen's view of her mother and she began to feel more empathy towards her. Staff recommended family therapy and both the mother and the daughter were agreeable to it. While the teen initially felt that the mother was the only one of concern, there was some reflection that perhaps she could benefit from therapy as well. Story #3: Recently, a mother and her 18-year-old daughter came to Fremont Healthy Start for assistance in applying for Medi-Cal. When the Family Resource Specialist noticed that the daughter showed no emotional expression and that the mother looked sad and was crying, the Family Resource Specialist began asking questions about what happened. The daughter spoke about not wanting to go back to school because she was worried she would have charges pressed against her. The daughter was pulled aside to get more information, but she was difficult to engage. The daughter began speaking about anti-psychotic medications that she had been given, and talked about hearing voices and how she had been 5150'd by the school. The Family Resource Specialist then spoke with her mother and asked if her daughter was receiving treatment or if there was a diagnosis. The mother said no because she felt that her daughter's situation was more of a behavior issue than a mental health issue. However, the mother shared that she was becoming concerned about leaving her daughter alone after a recent incident in which her daughter was violent with her younger sister. Staff discussed the importance of getting treatment and medication. Staff encouraged the daughter to take the medication she had been issued at the emergency room and to follow-up with their doctor. Staff completed their Medi-Cal application, provided a FERC referral, and accompanied them to the FERC appointment to speak to the parent partner. Staff will continue to follow up with the mother to ensure that she feels supported and is following through on treatment goals.

Additional Information

Please include the number of clients and/or contacts you estimate to serve in:

FY 19/20: 1000
FY 20/21: 1000

Please tell us about any changes you intend to make to your program over the next two fiscal years and explain your rationale for making these changes: There are no significant changes planned over the next two fiscal years. We will use our evaluation data to continue to refine our services and process.

Outreach for Increasing Recognition of Early Signs of Mental Illness PEI Data Report FY 18/19

MHSA Program Number: PEI 13
Program Name: PEERS, Wellness, Recovery & Resiliency Services-WRAP Planning

4 ongoing WRAP groups in English and Spanish at various Alameda County locations, including one for transition-age youth. Reach approximately 300 consumers and family members with WRAP orientations and promote consumer leadership by training and supporting consumers to become WRAP facilitators.

GENERAL INFORMATION & TOTAL NUMBERS SERVED

Total Numbers Served through PEI MHSA		
Number of unduplicated individuals your program serves who are **at-risk** of developing a mental health problem or serious mental illness (SMI)	**A**	1,027
Number of unduplicated individuals your program serves who show **early signs** of forming a more severe mental illness	**B**	
Number of unduplicated individual family members served indirectly by your program:	**C**	
Grand TOTAL of unduplicated individuals served in the Quarter that you are reporting about. [This number (D) should = A+B+C.]	**D**	1,027

DEMOGRAPHICS

Age Group (Unduplicated)	
Children/Youth (0-15)	76
Transition Age Youth (16-25)	183
Adult (26-59)	320
Older Adult (60+)	70
Unknown/ Declined to Answer	378

Race (Please mark only one choice) *If Hispanic or Latino, choose "Another race not listed."*	
American Indian or Alaska Native	13
Asian	47
Black or African American	380
Native Hawaiian or other Pacific Islander	8
White	195
More than one race	87
Another race not listed	79
Unknown/ Declined to Answer	218

Sexual Orientation (Please mark only one choice)	
Gay or Lesbian	22
Heterosexual or Straight	147
Bisexual	12
Questioning or unsure of sexual orientation	3
Queer	3
Another sexual orientation not listed	8
Unknown/Decline to Answer	832

Ethnicity /Cultural Heritage (Please mark only once choice)	
If Hispanic or Latino, please specify:	
Caribbean	
Central American	2
Mexican/Mexican--American/Chicano	12
Puerto Rican	
South American	
Another Hispanic/Latino ethnicity not listed	
Unknown/Declined to Answer	102
If Non-Hispanic or Non-Latino, please specify:	
African	2
African American	3
Asian Indian/South Asian	2
Cambodian	1
Chinese	6
Eastern European	3
European	6
Filipino	20
Japanese	1
Korean	1
Middle Eastern	4
Vietnamese	5
Other Non-Hispanic or Non-Latino ethnicity not listed	23
More than one ethnicity	0
Unknown /Declined to Answer	833

Primary Language (Please mark only one choice)	
English	205
Spanish	29
Farsi	
Cantonese	7
Mandarin	1
Other Chinese Dialects	
Vietnamese	4
Korean	
Tagalog	
Other Filipino Dialect	
Japanese	
Laotian	
Cambodian	
Mien	
Hmong	
Samoan	1
Thai	
Russian	
Polish	
German	
Italian	
Turkish	
Hebrew	1
French	
Portuguese	
Armenian	
Arabic	1
Sign ASL	1
Other primary language not listed	5
Unknown/ Decline to Answer	772

Gender Identity (Please mark both parts A & B)	
A) Assigned sex at birth: (Please mark only one choice)	
Male	
Female	
Other sex not listed (e.g. Intersex)	
Unknown/Decline to Answer	1,027
B) Current Gender Identity: (Please mark only one choice)	
Male	432
Female	448
Transgender	1
Genderqueer	2
Questioning or Unsure of Gender Identity	1
Another Gender Identity not listed	10
Unknown/Decline to Answer	131

Disability Status (Please mark all that apply)	
None	98
Yes. If yes, please specify (choose from list below):	
Difficulty Seeing	4
Difficulty hearing, or having speech understood	2
Mental Domain	55
Physical/Mobility Domain	18
Chronic Health Condition	7
Another disability not listed	26
Unknown/Decline to Answer	817

Veteran Status (Please mark only one choice)	
Yes	10
No	205
Unknown/Decline to Answer	812

REQUIRED STRATEGY: IMPROVE TIMELY ACCESS TO MENTAL HEALTH SERVICES FOR UNDERSERVED POPULATIONS

a. Who is/are the underserved target population/s your program is serving (e.g. TAY, Southeast Asian, etc.)? Mental health consumers, primarily people of color, including TAY and older adults.

b. Number of separate paper referrals to an ACBHCS PEI-funded program. (This can be a provider's internal ACBHCS PEI-funded prevention or early intervention program OR an external PEI-funded ACBHCS prevention or early intervention program): 8

c. Number of individuals followed through on referral & engaged in an ACBHCS PEI-funded program: 7

d. Average time in weeks between when a paper referral was given to individual by your program and the individual's first in person appointment with the ACBHCS PEI-funded provider. N/A The referrals were not for "appointments" per se. For example, one participant was referred to FERC and called the FERC Warm Line, while another participant was referred to the Pool of Consumer Champions (POCC) and became a member of the POCC's SAGA Committee. Four participants were connected to peer specialist job training programs (BestNow!) and Alameda County Accelerated Peer Specialist program). We introduced TAY Mentors to the Independent Living Skills Program, Youth Employment Project, and the Unity Council, among other community services.

e. Describe ways your program encouraged access to services and follow-through on the above referrals: Our primary method is to provide personal encouragement and information about participants' options, since self-determination is a core principle of our program model.

f. Any additional information to report on (optional): Many of the referrals our participants need are for services related to basic needs such as food and housing. For example, we have referred participants experiencing homelessness or housing crisis to 2-1-1, so that they could access the Coordinated Entry System.

OUTREACH. THIS SECTION IS *REQUIRED ONLY* FOR OUTREACH PROGRAMS. OTHERWISE, IT IS OPTIONAL

Number of potential responders: N/A

List type of setting(s) in which the potential responders received outreach and the type(s) of potential responders engaged in each setting:

Type of Setting(s) (ex: school, place of worship, clinic)	**Type(s) of Potential Responders** (ex: principals, teachers, parents, nurses)
	N/A. Our Stigma and Discrimination Reduction PEI Data Report provides information on PEERS' outreach activities.

NARRATIVE

a. Choose two of the above principles and describe how your program upholds or achieves those principles. Please speak to each principle separately and specifically describe how your program activities align with that corresponding principle.

Principle #1: Wellness and Recovery How does your program align with this principle? As a diverse community of people with mental health experiences, PEERS pursues the vision of a world where people can freely choose among many mental health options that address the needs of the whole person. Wellness and recovery are central to everything we do. PEERS' keystone service is Wellness Recovery Action Planning (WRAP). WRAP is an evidence-based practice used worldwide by people dealing with mental health challenges. PEERS provides WRAP groups free of charge and open to the public in both English and Spanish in various locations in Alameda County, in addition to groups that are available to participants in programs of other ACBH providers, such as the South County Homeless Project, the East Bay Community Recovery Project, and the TRUST Clinic. We also tailor WRAP groups for transition-age youth of color, for the LGBTQ community, and for women. Because WRAP groups always are facilitated by peers – people who use WRAP in their own lives – WRAP groups not only give participants tools for wellness and recovery, but model that wellness and recovery are possible. All PEERS programming, including WRAP and the TAY program, use the language of wellness and recovery rather than clinical or diagnostic language. The focus of our groups always is on strengths, goals, and tools rather than symptoms or perceived deficits. Participants are supported to generate their own strategies to meet goals that they set for their wellness, while exchanging peer support. Moreover, participants who complete a full cycle of WRAP groups are eligible to be

trained to become WRAP facilitators, which offers them opportunities for leadership, professional development, and generating income. Our TAY Wellness workshops also communicate these same wellness and recovery principles. During FY18-19, TAY Wellness workshop topics included self-advocacy and motivation, culture and social media, foster care, racism, intimate partner violence, and eliminating mental health stigma.

Principle #2: Community Collaboration How does your program align with this principle? PEERS collaborates with different facets of the community in multiple ways. For example, through our collaborative relationships with the Alameda County Network of Mental Health Clients, BestNow! internship program, as well as the Alameda County Accelerated Peer Specialist Program (ACAPS), we connect our participants to employment training and employment support. Several of our staff members are alumni of BestNow!, and our practice of sponsoring interns and hiring BestNow! graduates also increases employment opportunities for mental health consumers. New TAY program partnerships during this fiscal year included Acta Non Verba Youth Urban Farm Project (ANV); Beats, Rhymes and Life (BRL); Youth Employment Partnership (YEP); and Oakland Unified School District (OUSD) -- Dewey Academy, Oakland High's African American Male Achievement class, and the African American Male Achievement program in particular. In the fall, the TAY mentors facilitated wellness workshops at YEP, Dewey Academy (a continuation high school), and Oakland High. Not only were the workshops very well received by the youth participants, but we were able to reach young people affected by trauma who are in settings that don't typically address mental health directly. By facilitating wellness workshops in settings like these, the PEERS' TAY program is making space for young people to understand and explore wellness outside of the medical model of mental health. In the spring, we facilitated a wellness workshop for BRL participants on community connections, and partnered with ANV to provide multi-session wellness workshops focusing on nutrition and mental health, housing, budgeting and financial literacy, housing, and community connections for the youth participants in ANV's summer program.

b. Please tell us about the following…

Implementation Challenges: PEERS WRAP program did not encounter any significant implementation challenges during this fiscal year. The primary implementation challenge we faced in our TAY program during this pilot year was attrition among the TAY mentors in the on-the-job training aspect of the program. In our recruitment and hiring, we sought out young people with lived experience of mental health challenges. Over the course of the program pilot, however, we learned that it takes more intensive staffing (including a case manager) to support young people who face not only substantial emotional and behavioral challenges, but also major family dysfunction, unstable housing, physical health crises, etc. As well, there was a mismatch between the skill level of the TAY mentors and PEERS' expectations of them as employees.

Successes: Successes include very strong results from our post-activity surveys of participants WRAP groups and TAY wellness workshops. Among the highlights were the following: 88% of participants in WRAP sessions and in TAY wellness workshops reported understanding more about their own wellness and mental health after participating. 93% of WRAP participants and 92% of TAY wellness workshop participants reported that the group or workshop was useful to them. 93% of WRAP participants and 79% of TAY wellness workshop participants agreed or strongly agreed with the statement "I see myself using what I learned today in the future." During FY18-19, two primary strategies have enabled us to take the quality of our WRAP program to the next level: creating a new staff position and increasing the skills of WRAP facilitators through WRAP Facilitator Mentoring meetings. The new staff position has increased our capacity to provide close supervision of all of our WRAP facilitators, further developing their skills. We restructured our WRAP Facilitator Mentoring meetings to increase the extent to which these meetings develop facilitators' skills, which has been well received.

i. Lessons Learned: From the attrition in our pilot cohort of TAY mentors, we learned that we need to change the design of the TAY program. Based on what we learned, we will eliminate the on-the-job training part of the program, which was not as successful, to focus on the most successful elements of the program: bimonthly TAY leadership meetings (which allow for the flexibility that young people facing substantial life challenges need), and TAY wellness workshops.

ii. Relevant Examples of Success/Impact (e.g. a client success story) Reminder: Please do not use real client names: WRAP group participants consistently report learning tools they can use to support their own wellness. Things they learn include (in their own words): "How to better care for myself." "Having an action plan to combat life's stressors is important." "How to make plans for work and my mental health." "How to have compassion for myself." "I learned about my triggers and actually came up with ways to identify and deal with my reaction to the triggers." Participants in TAY wellness workshops reported that the workshops were powerful. Responses to a question about what they learned in the workshops included: "I learned that how you grew up can affect your mental health." "Needing someone to talk to is okay." "I learned that opening up to people about your mental health can help you." "Something I learned is that it's ok to cry." "All my brothers

made me feel cool." "I learned about places you can go to if you are seeking help." "We engaged with each other. It was amazing. I just wish we had more time."

ADDITIONAL INFORMATION

Please include the number of clients and/or contacts you estimate to serve in:

FY 19/20: 1,040 (approximately 210 through the TAY program, 825 through WRAP, and 5 new participants through Hoarding and Cluttering)

FY 20/21: 1,040 (approximately 210 through the TAY program, 825 through WRAP, and 5 new participants through Hoarding and Cluttering)

Please tell us about any changes you intend to make to your program over the next two fiscal years and explain your rationale for making these changes: The major change we plan to our WRAP program is the addition of a second Spanish-language WRAP group. As described above, we are redesigning the TAY program based on what we learned from the attrition from on-the-job training in our pilot cohort of TAY mentors. We will eliminate the on-the-job training part of the program, to focus on the most successful elements of the program: bimonthly TAY leadership meetings (which allow for the flexibility that young people facing substantial life challenges need), and TAY wellness workshops. We will begin a new Hoarding and Cluttering project in FY 19-20, which will entail facilitating two 15-session support groups following the evidence-based curriculum, Buried in Treasures. We predict that the majority of participants in these Hoarding and Cluttering groups will already be engaged in PEERS programs through WRAP, so the groups will not be likely to increase our numbers served by a great deal.

Outreach for Increasing Recognition of Early Signs of Mental Illness PEI Data Report FY 18/19

MHSA Program Number: PEI 19
Program Name: Older Adults Peer Support- Peer Coaching for Older Adult LGBT Community (City of Fremont)

Providing supportive services to the LGBT older adult community. Providing outreach and prevention services to enhance existing programming in the older adult population. Reducing social isolation by providing services that encourage and support positive social support networks and relationships that reduce the risk of prolonged suffering. Increase self-confidence among target population. Increase access to needed community resources. Offering 1 to 1 time with trained LGBT Peer Coaches. Offering Support Groups and Education Resources.

General Information & Total Numbers Served

Total Numbers Served through PEI MHSA		
Number of unduplicated individuals your program serves who are at-risk of developing a serious mental illness (SMI)	**A**	5
Number of unduplicated individuals your program serves who show early signs of forming a more severe mental illness	**B**	0
Number of unduplicated individual family members served indirectly by your program:	**C**	0
Grand TOTAL of unduplicated individuals served in the Quarter that you are reporting about. [This number (D) should = A=B+C.]	**D**	5

DEMOGRAPHICS

Age Group (Unduplicated)	
Children/Youth (0-15)	
Transition Age Youth (16-25)	
Adult (26-59)	
Older Adult (60+)	
Unknown/ Declined to Answer	

Race (Please mark only one choice) *If Hispanic or Latino, choose "Another race not listed."*	
American Indian or Alaska Native	
Asian	1
Black or African American	
Native Hawaiian or other Pacific Islander	
White	3
More than one race	
Another race not listed	
Unknown/ Declined to Answer	

Sexual Orientation (Please mark only one choice)	
Gay or Lesbian	3
Heterosexual or Straight	2
Bisexual	
Questioning or unsure of sexual orientation	
Queer	
Another sexual orientation not listed	
Unknown/Decline to Answer	

Ethnicity /Cultural Heritage (Please mark only once choice)	
If Hispanic or Latino, please specify:	
Caribbean	
Central American	
Mexican/Mexican--American/Chicano	1
Puerto Rican	
South American	
Another Hispanic/Latino ethnicity not listed	
Unknown/Declined to Answer	
If Non-Hispanic or Non-Latino, please specify:	
African	
African American	
Asian Indian/South Asian	1
Cambodian	
Chinese	
Eastern European	
European	
Filipino	
Japanese	
Korean	
Middle Eastern	
Vietnamese	
Other Non-Hispanic or Non-Latino ethnicity not listed	
More than one ethnicity	
Unknown /Declined to Answer	

Primary Language (Please mark only one choice)	
English	x
Spanish	
Farsi	
Cantonese	
Mandarin	
Other Chinese Dialects	
Vietnamese	
Korean	
Tagalog	
Other Filipino Dialect	
Japanese	
Laotian	
Cambodian	
Mien	
Hmong	
Samoan	
Thai	
Russian	
Polish	
German	
Italian	
Turkish	
Hebrew	
French	
Portuguese	
Armenian	
Arabic	
Sign ASL	
Other primary language not listed	
Unknown/ Decline to Answer	

Gender Identity (Please mark both parts A & B)	
A) Assigned sex at birth: (Please mark only one choice)	
Male	1
Female	4
Other sex not listed (e.g. Intersex)	
Unknown/Decline to Answer	
B) Current Gender Identity: (Please mark only one choice)	
Male	1
Female	4
Transgender	
Genderqueer	
Questioning or Unsure of Gender Identity	
Another Gender Identity not listed	
Unknown/Decline to Answer	

Disability Status (Please mark all that apply)	
None	
Yes. If yes, please specify (choose from list below):	
Difficulty Seeing	
Difficulty hearing, or having speech understood	
Mental Domain	5
Physical/Mobility Domain	2
Chronic Health Condition	5
Another disability not listed	
Unknown/Decline to Answer	

Veteran Status (Please mark only one choice)	
Yes	
No	5
Unknown/Decline to Answer	

IMPROVE TIMELY ACCESS TO MENTAL HEALTH SERVICES FOR UNDERSERVED POPULATIONS

a. Who is/are the underserved target population/s your program is serving (e.g. TAY, Southeast Asian, etc.)?
LGBT Older Adult Population

b. Number of separate paper referrals to an ACBHCS PEI-funded program. (This can be a provider's internal ACBHCS PEI-funded prevention or early intervention program OR an external PEI-funded ACBHCS prevention or early intervention program): N/A

c. Number of individuals followed through on referral & engaged in an ACBHCS PEI-funded program: N/A

d. Average time in weeks between when a paper referral was given to individual by your program and the individual's first in person appointment with the ACBHCS PEI-funded provider. N/A

e. Describe ways your program encouraged access to services and follow-through on the above referrals: N/A

OUTREACH FOR INCREASING RECOGNITION OF EARLY SIGNS OF MENTAL ILLNESS

Number of potential responders: None at this time

List type of setting(s) in which the potential responders received outreach and the type(s) of potential responders engaged in each setting:

Type of Setting(s) (ex:	**Type(s) of Potential Responders** (ex: principals, teachers, parents, nurses)
Various local Universities	Met with the University School of social work Department to present LGBT senior
(comm. Based setting)	coaching program. Discussed service collaboration ie: sharing resources for the LGBT
	clients and information and referrals.
Social Services	Outreached to Area on Aging to disseminate info: re: LGBT senior peer coaching

NARRATIVE

a. Choose <u>two</u> of the above principles and describe how your program upholds or achieves those principles. Please speak to each principle separately and specifically describe how your program activities align with that corresponding principle.

Principle #1: Community Collaboration. How does your program align with this principle? The program strongly collaborates with various community organization/mental health providers in informing LGBT older adult population about our program and ways for easier service access. Program staff also outreached to various food pantries where seniors go for food assistance services. This quarter, writer presented the program to Social Services Area on Aging for potential service collaboration and referrals.

Principle #2: Wellness and Recovery. How does your program align with this principle? Our LGBT peer coaching program for older adults involve clients to actively participate in developing and defining their own treatment goals so they can sustain their recovery and resiliency needed to live fulfilling and productive lives and increasing their stability and optimism.

Principle # 3: Cultural Competence: The program continues to offer LGBT Senior Peer coach and Senior Mobile Mental Health staff opportunities to advance their knowledge about LGBT population via training and education. Senior Peer coach also has a direct access to the program interdisciplinary team members for consultation. The program supports collaborative team practice among staff in addressing client and family's well-being, recovery and resiliency.

b. Please tell us about the following…

i. Implementation Challenges: Prejudice and stigma continue to be a major barrier in client's help seeking behavior. The program continues to do outreach work to various community agencies (both public and private) but the response has been very slow. Periodic follow up is required to remind them of available services the program offers. LGBT older adult population continues to need strong advocacy work in order to help them access services. It has been very challenging to recruit potential clients to participate in the program. Despite active program promotions in the community, referrals have not found its way to the program.

ii. Successes: Existing clients continue to benefit from the program. Working relationship has improved making it a lot easier to work on specific goals.

iii. Lessons Learned: Identify key members of the LGBT community, support them by providing them with multiple services and resources available to LGBT population so that it will strengthen their population base.

We will continue to promote our program to establish working relationship with their population base.

iv. Relevant Examples of Success/Impact (e.g. a client success story) Reminder: Please do not use real client names: With our continued services and support, one of the program client is now very comfortable working with his LGBT senior peer coach. In addition, client's other support person is actively coordinating and supporting the services the program provides for the client.

EVALUATION PLAN UPDATE

a. Please describe, in 1-2 sentences, your effort to collect feedback from program participants (method used). Senior peer coach attends weekly supervision from a licensed Clinical Social Worker staff which is an opportunity to collect feedback re: participant's satisfaction in receiving services. In addition, clients are invited to participate in different focus groups to gather feedback on the challenges they experience and recommendations on how to improve the program. Senior Peer Coach attended the Tri City Elder Coalition and presented the program to the group.

b. Describe the tool used to collect data.
Weekly supervision and attendance/ participation in various focus group.

c. Summarize the results. In weekly supervision, coach will update supervisor of status of his supportive relationship with his peers. Coach also discusses some of his challenges he may have in working with his peers. Supervisor and senior peer coach address these challenges and working on problem solving areas of concerns.

d. What was learned from the participant feedback (**1-2 key points**)?
Participants reported that his senior peer coach is dependable and empathetic. However, one of the clients stated that he feels a bit guilty using coach's time listening to him. "I feel I may be a burden to him knowing that he has his own mental health challenges as well".

e. Describe how the findings were reviewed by staff. Supervisor meets with senior peer coach and discusses status of his working relationship with his peer. Supervisor ensures that peer coach is not experiencing increase in symptoms which will lead to burn out and affect his ability to provide support to his peers. If peer coaches observe that symptoms are recurring, supervisor will sit down with the peer to discuss ways to address their concerns or supervisor will recommend peer sees his/her regular therapist to increase therapy sessions.

f. What programmatic change(s) were or will be adopted as a result of the findings? When will changes be made and how will the changes impact programming? None at this time, but will continue to provide weekly supervision to the peer coach to help him maintain /sustain his emotional stability.

Continue to offer education and training to increase his knowledge of the LGBT population.
Senior Mobile Mental Health Interdisciplinary team and the City of Fremont Case Management Team will continue to provide support to the coach.

g. What issues or challenges with the Evaluation Plan are you having? What technical assistance do you need?
The program has not been able to recruit enough senior LGBT clients to receive services from peer.
Despite increased program promotions and outreach efforts, we haven't received referrals from the various community service providers. The program is planning to rework our marketing strategies in order to disseminate program information to the community.

ADDITIONAL INFORMATION

Please include the number of clients and/or contacts you estimate to serve in:

FY 19/20: Same number per program contract.
FY 20/21: Same number per program contract

Please tell us about any changes you intend to make to your program over the next two fiscal years and explain your rationale for making these changes: Client's admission to the program has been very difficult thus we haven't been able to meet contracted # of clients to be served. This year, we are going to try to change our fliers/brochures to convey more the intent of the program. We also plan to implement a different strategy for the program to become more visible in the community via attending community meetings, showing movies about LGBT to our senior population. We coordinate and collaborate these efforts with different programs within the City of Fremont.

Outreach for Increasing Recognition of Early Signs of Mental Illness PEI Data Report FY 18/19

MHSA Program Number: PEI 20B
Program Name: Culturally Responsive PEI programs for the African American Community- Black Men Speak

Black Men Speak (BMS) is an inspirational speaker's bureau that aims to end the trauma, discrimination and stigma associated with mental health and substance abuse challenges.

General Information & Total Numbers Served

Total Numbers Served through PEI MHSA		
Number of unduplicated individuals your program serves who are **at-risk** of developing a mental health problem or serious mental illness (SMI)	**A**	352
Number of unduplicated individuals your program serves who show **early signs** of forming a more severe mental illness	**B**	
Number of unduplicated individual family members served indirectly by your program:	**C**	
Grand TOTAL of unduplicated individuals served in the Quarter that you are reporting about. [This number (D) should = A+B+C.]	**D**	352

DEMOGRAPHICS

Age Group (Unduplicated)	
Children/Youth (0-15)	1
Transition Age Youth (16-25)	30
Adult (26-59)	176
Older Adult (60+)	36
Unknown/ Declined to Answer	109

Race (Please mark only one choice) *If Hispanic or Latino, choose "Another race not listed."*	
American Indian or Alaska Native	2
Asian	12
Black or African American	121
Native Hawaiian or other Pacific Islander	1
White	20
More than one race	17
Another race not listed	11
Unknown/ Declined to Answer	168

Sexual Orientation (Please mark only one choice)	
Gay or Lesbian	0
Heterosexual or Straight	0
Bisexual	0
Questioning or unsure of sexual orientation	0
Queer	0
Another sexual orientation not listed	0
Unknown/Decline to Answer	352

Ethnicity /Cultural Heritage (Please mark only once choice)	
If Hispanic or Latino, please specify:	
Caribbean	0
Central American	0
Mexican/Mexican--American/Chicano	2
Puerto Rican	0
South American	0
Another Hispanic/Latino ethnicity not listed	0
Unknown/Declined to Answer	22
If Non-Hispanic or Non-Latino, please specify:	
African	2
African American	108
Asian Indian/South Asian	1
Cambodian	1
Chinese	2
Eastern European	
European	1
Filipino	3
Japanese	
Korean	
Middle Eastern	
Vietnamese	3
Other Non-Hispanic or Non-Latino ethnicity not listed	2
More than one ethnicity	3
Unknown /Declined to Answer	202

Primary Language (Please mark only one choice)	
English	0
Spanish	0
Farsi	0
Cantonese	0
Mandarin	0
Other Chinese Dialects	0
Vietnamese	0
Korean	0
Tagalog	0
Other Filipino Dialect	0
Japanese	0
Laotian	0
Cambodian	0
Mien	0
Hmong	0
Samoan	0
Thai	0
Russian	0
Polish	0
German	0
Italian	0
Turkish	0
Hebrew	0
French	0
Portuguese	0
Armenian	0
Arabic	0
Sign ASL	0
Other primary language not listed	0
Unknown/ Decline to Answer	352

Gender Identity (Please mark both parts A & B)	
A) Assigned sex at birth: (Please mark only one choice)	
Male	18
Female	2
Other sex not listed (e.g. Intersex)	0
Unknown/Decline to Answer	332
B) Current Gender Identity: (Please mark only one choice)	
Male	93
Female	71
Transgender	0
Genderqueer	1
Questioning or Unsure of Gender Identity	0
Another Gender Identity not listed	0
Unknown/Decline to Answer	187

Disability Status (Please mark all that apply)	
None	
Yes. If yes, please specify (choose from list below):	
Difficulty Seeing	2
Difficulty hearing, or having speech understood	2
Mental Domain	15
Physical/Mobility Domain	2
Chronic Health Condition	2
Another disability not listed	0
Unknown/Decline to Answer	329

Veteran Status (Please mark only one choice)	
Yes	1
No	0
Unknown/Decline to Answer	351

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

OUTREACH. THIS SECTION IS *REQUIRED ONLY* FOR OUTREACH PROGRAMS. OTHERWISE, IT IS OPTIONAL

Number of potential responders: 218

List type of setting(s) in which the potential responders received outreach and the type(s) of potential responders engaged in each setting:

Type of Setting(s) (ex: school, place of worship, clinic)	**Type(s) of Potential Responders** (ex: principals, teachers, parents, nurses)
Wellness Centers	Caseworkers, client reps, managers, consumers, family members, directors
Recovery Centers	Caseworkers, managers, client reps, consumers, directors, family members, support
Conditional Release	Caseworkers, managers, client reps, consumers, directors, family members, support
Religious Organizations	Spiritual leaders, pastors, families, Consumers, directors, general public
Festivals	General public, families, consumers, directors, organization reps

NARRATIVE

a. Choose <u>two</u> of the above principles and describe how your program upholds or achieves those principles. Please speak to each principle separately and specifically describe how your program activities align with that corresponding principle.

Principle #1: Community Collaboration How does your program align with this principle? BMS has developed some unique partnerships with organizations in media and broadcasting to increase our reach and influence in our targeted community, as well as with housing advocates and job centers to stay updated on information related to employment openings and housing options for individuals, the homeless, low-income families, and seniors. Through the Alameda County Community Corrections Partnership Advisory Board (CAB Committee), we have also established a solid partnership with re-entry programs that provide housing, resources, counseling, computer training, and job referrals for individuals returning into society. BMS hopes that by working together with these various organizations we will increase our reach to those impacted and help create healthier communities.

Principle #2: Wellness and Recovery How does your program align with this principle? BMS encourages and supports individuals through recovery by meeting each individual right where they are and working with them without stigma, judgment, or discrimination. We have integrated resources for alternative therapies that focus on the whole person, including mental, physical, and spiritual aspects. We promote positive self-talk, help clients develop WRAP plans, and encourage individuals to help others by sharing their journeys to wellness and recovery. BMS members, by sharing our own unique personal stories, inspire clients and prove that wellness and recovery are possible. We strategically promote the concept that the power of recovery lies in everyone and that clients have the power to make choices that support their own greater well-being.

b. Please tell us about the following…

i. Implementation Challenges: Member participation in in speaking engagements was down and has been one of our biggest challenges throughout the past two quarters. Members' work schedules continue to conflict with dates and times of scheduled activities. In an effort to rectify this we have increased our outreach efforts and established new partnerships with community based organizations outside of our current network of partners, that offer flexibility in days, times, and locations to allow BMS members to engage in events and activities outside of normal business hours.

ii. Successes: BMS has been dedicated to enlightening and reducing stigma and discrimination against those with mental health and substance abuse challenges. We are pleased to have successfully exceeded our objectives: the number of speakers on our roster, and speakers' reports of satisfaction, empowerment, and increased hopefulness. Our audience member objectives were also exceeded.

iii. Lessons Learned: Offer flexible times and locations and provide transportation for members to and from

events when needed.

iv. Relevant Examples of Success/Impact (e.g. a client success story) Reminder: Please do not use real client names: "I am truly thankful to BMS for their support in my employment endeavors and for their help giving me the confidence I need to share my story and encouragement to pursue my dreams. BMS truly is a brotherhood, a family, a group of individuals working together to help one another. I don't know where I would be if I had not become a member. I am grateful that they were able to meet me where I was in my journey to recovery. Today I feel much better about myself, I am working, I'm taking care of my kids and I am doing awesome at maintaining my Wellness and Recovery."

ADDITIONAL INFORMATION

Please include the number of clients and/or contacts you estimate to serve in:

FY 19/20: 250
FY 20/21: 300

Please tell us about any changes you intend to make to your program over the next two fiscal years and explain your rationale for making these changes: BMS will continue to grow our partnerships and impact in an effort to increase our target population's knowledge of resources and services available to them within the community. BMS is currently in the planning stages of developing additional services. In the coming fiscal year 2019-20 we are looking to facilitate a weekly Re-Entry Support Group with a focus on individuals returning to society and those who have suffered/suffer with mental health and substance abuse challenges. Also, through audience feedback we are actively recruiting women to be a part of the women's section of Black Men Speak speaker's bureau. Over the next two fiscal years BMS plans to offer additional support groups for our target population and open up a women's chapter of our organization. Through our outreach efforts we have discovered that in order to break the stigma associated with mental health within the communities of African American Males and Men of Color we need strategic groups that deal with issues that confront targeted issues. At each speaking event we have had a mixed crowd and after reviewing audience responses, there has been numerous positive feedback regarding our women speakers. We'd plan on exploring ways that we can support this demographic in the future.

Outreach for Increasing Recognition of Early Signs of Mental Illness PEI Data Report FY 18/19

MHSA Program Number: PEI 20C
Program Name: Culturally Responsive PEI Programs for the African American Community- African American Family Support

Free quarterly workshops offer help to family members who seek support and care for those living with mental illness and/or who are substance addicted. The program provides opportunities to talk with mental health and substance use professionals and share stories with peer families.

General Information & Total Numbers Served

Total Numbers Served through PEI MHSA		
Number of unduplicated individuals your program serves who are **at-risk** of developing a mental health problem or serious mental illness (SMI)	**A**	
Number of unduplicated individuals your program serves who show **early signs** of forming a more severe mental illness	**B**	
Number of unduplicated individual family members served indirectly by your program:	**C**	88
Grand TOTAL of unduplicated individuals served in the Quarter that you are reporting about. [This number (D) should = A+B+C.]	**D**	200

DEMOGRAPHICS

Age Group (Unduplicated)	
Children/Youth (0-15)	2
Transition Age Youth (16-25)	3
Adult (26-59)	26
Older Adult (60+)	30
Unknown/ Declined to Answer	1

Race (Please mark only one choice) *If Hispanic or Latino, choose "Another race not listed."*	
American Indian or Alaska Native	2
Asian	
Black or African American	59
Native Hawaiian or other Pacific Islander	
White	
More than one race	
Another race not listed	2
Unknown/ Declined to Answer	

Sexual Orientation (Please mark only one choice)	
Gay or Lesbian	
Heterosexual or Straight	
Bisexual	
Questioning or unsure of sexual orientation	
Queer	
Another sexual orientation not listed	
Unknown/Decline to Answer	

Ethnicity /Cultural Heritage (Please mark only once choice)	
If Hispanic or Latino, please specify:	
Caribbean	1
Central American	
Mexican/Mexican--American/Chicano	1
Puerto Rican	
South American	
Another Hispanic/Latino ethnicity not listed	
Unknown/Declined to Answer	1
If Non-Hispanic or Non-Latino, please specify:	
African	5
African American	36
Asian Indian/South Asian	
Cambodian	
Chinese	
Eastern European	1
European	1
Filipino	
Japanese	
Korean	
Middle Eastern	
Vietnamese	
Other Non-Hispanic or Non-Latino ethnicity not listed	
More than one ethnicity	
Unknown /Declined to Answer	

Primary Language (Please mark only one choice)	
English	
Spanish	
Farsi	
Cantonese	
Mandarin	
Other Chinese Dialects	
Vietnamese	
Korean	
Tagalog	
Other Filipino Dialect	
Japanese	
Laotian	
Cambodian	
Mien	
Hmong	
Samoan	
Thai	
Russian	
Polish	
German	
Italian	
Turkish	
Hebrew	
French	
Portuguese	
Armenian	
Arabic	
Sign ASL	
Other primary language not listed	
Unknown/ Decline to Answer	

Gender Identity (Please mark both parts A & B)	
A) Assigned sex at birth: (Please mark only one choice)	
Male	
Female	
Other sex not listed (e.g. Intersex)	
Unknown/Decline to Answer	
B) Current Gender Identity: (Please mark only one choice)	
Male	10
Female	53
Transgender	
Genderqueer	
Questioning or Unsure of Gender Identity	
Another Gender Identity not listed	
Unknown/Decline to Answer	

Disability Status (Please mark all that apply)	
None	
Yes. If yes, please specify (choose from list below):	
Difficulty Seeing	
Difficulty hearing, or having speech understood	
Mental Domain	
Physical/Mobility Domain	
Chronic Health Condition	
Another disability not listed	
Unknown/Decline to Answer	

Veteran Status (Please mark only one choice)	
Yes	
No	
Unknown/Decline to Answer	

OUTREACH. THIS SECTION IS *REQUIRED ONLY* FOR OUTREACH PROGRAMS

Number of potential responders: ***A total 88 family caregivers and friends attended the two meetings.***

List type of setting(s) in which the potential responders received outreach and the type(s) of potential responders engaged in each setting:

Type of Setting(s) (ex: school, place of worship, clinic)	**Type(s) of Potential Responders** (ex: principals, teachers, parents, nurses)
North Oakland Senior	Family caregivers and friends of people with mental illness and/or substance abuse
Center	Family caregivers and friends of people with mental illness and/or substance abuse
Charles Porter Golden	Family caregivers and friends of people with mental illness and/or substance abuse
Recreation Center	Family caregivers and friends of people with mental illness and/or substance abuse

NARRATIVE

Choose two of the above principles and describe how your program upholds or achieves those principles. Please speak to each principle separately and specifically describe how your program activities align with that corresponding principle.

Principle #1: Cultural Competence How does your program align with this principle? The AAFOP believes that there are core elements of African American culture. Among them are the belief in a common history, and values placed on communal activity and the extended family. Call and response is an appreciated verbal form in music and in areas of public association. The workshops open with recitation of a poem, using call and response to begin building group cohesion. The workshops close with the group singing the Negro National Anthem, another cohesion-building experience calling up a common historical reality as well as hope for the future. The facilitator and key speakers validate participants' expressions of racial conditions, whether they are cultural constraints, social limitations or traditional strengths.

Principle #2: Client, Consumer, and Family Involvement How does your program align with this principle? Having information about the service systems is an essential first step in family involvement and we are providing information including where to turn to get help in utilizing the systems (the Family Education and Resource Center is a prime source of help). Participants in the meetings are also invited to attend the monthly African American Family Support Group meetings which offer a way for families to become involved and to provide mutual support.

a. Please tell us about the following…

i. Implementation Challenges: Finding time to cover more topics and a way to have someone on site to help family caregivers and friends.

ii. Successes: We have developed a successful meeting format, recruited several very good presenters and made progress in identifying the main challenges these family caregivers and friends face. It is clear to us that those who attend these meetings have very positive feelings about sharing and learning together with others who are facing similar challenges.

iii. Lessons Learned**:** Meeting attendees would like to learn about more topics than we can cover in the allotted time. We need to secure additional resources in order to hold additional meetings and have someone present at meetings who can help those with questions.

iv. Relevant Examples of Success/Impact (e.g. a client success story) Reminder: Please do not use real client names: **N/A**

ADDITIONAL INFORMATION

Please include the number of clients and/or contacts you estimate to serve in:

FY 19/20: We hope to serve many additional family caregivers, but doing so will require additional resources.
FY 20/21: We hope to continue to increase the number of family caregivers and friends we serve; this will require additional resources.

Please tell us about any changes you intend to make to your program over the next two fiscal years and explain your rationale for making these changes:

Outreach for Increasing Recognition of Early Signs of Mental Illness PEI Data Report FY 18/19

MHSA Program Number: PEI 22
Program Name: LGBT Support Services- Older & Out Adult LGBT Peer Supports

Older and Out provides drop-in therapy groups for LGBTQ older adults, age 60+ in north, central and east Alameda County. Groups are free, run for 90 minutes, welcome new members at any time, and refreshments are provided. Groups are facilitated by clinical interns assisted by local LGBTQ 60+ older adults.

General Information & Total Numbers Served:

Total Numbers Served through PEI MHSA		
Number of unduplicated individuals your program serves who are **at-risk** of developing a mental health problem or serious mental illness (SMI	**A**	7
Number of unduplicated individuals your program serves who show **early signs** of forming a more severe mental illness	**B**	0
Number of unduplicated individual family members served indirectly by your program:	**C**	NA
Grand TOTAL of unduplicated individuals served in the Quarter that you are reporting about. [This number (D) should = A+B+C.]	**D**	80

DEMOGRAPHICS

Age Group (Unduplicated)	
Children/Youth (0---15)	0
Transition Age Youth (16---25)	0
Adult (26---59)	7
Older Adult (60+)	73
Unknown/ Declined to Answer	

Race (Please mark only one choice) *If Hispanic or Latino, choose "Another race not listed."*	
American Indian or Alaska Native	2
Asian	4
Black or African American	12
Native Hawaiian or other Pacific Islander	0
White	51
More than one race	7
Another race not listed	1
Unknown/ Declined to Answer	3

Sexual Orientation (Please mark only one choice)	
Gay or Lesbian	66
Heterosexual or Straight	1
Bisexual	4
Questioning or unsure of sexual orientation	1
Queer	4
Another sexual orientation not listed	2
Unknown/Decline to Answer	2

Ethnicity /Cultural Heritage (Please mark only once choice)	
If Hispanic or Latino, please specify:	
Caribbean	
Central American	
Mexican/Mexican-American/Chicano	1
Puerto Rican	
South American	
Another Hispanic/Latino ethnicity not listed	
Unknown/Declined to Answer	7
If N on-Hispanic or Non-Latino, please specify:	
African	
African American	12
Asian Indian/South Asian	1
Cambodian	
Chinese	1
Eastern European	3
European	3
Filipino	
Japanese	
Korean	
Middle Eastern	
Vietnamese	
Other Non-Hispanic or Non-Latino ethnicity not listed	2
More than one ethnicity	2
Unknown /Declined to Answer	48

Primary Language (Please mark only one choice)	
English	76
Spanish	1
Farsi	
Cantonese	8
Mandarin	
Other Chinese Dialects	
Vietnamese	
Korean	
Tagalog	
Other Filipino Dialect	
Japanese	
Laotian	
Cambodian	
Mien	
Hmong	
Samoan	
Thai	
Russian	
Polish	
German	
Italian	
Turkish	
Hebrew	
French	
Portuguese	
Armenian	
Arabic	
Sign ASL	
Other primary language not listed	
Unknown/ Decline to Answer	3

Gender Identity (Please mark both parts A & B)	
A) Assigned sex at birth: (Please mark only one choice)	
Male	47
Female	30
Other sex not listed (e.g. Intersex)	2
Unknown/Decline to Answer	1
B) Current Gender Identity: (Please mark only one choice)	
Male	45
Female	29
Transgender	1
Genderqueer	4
Questioning or Unsure of Gender Identity	
Another Gender Identity not listed	1

Disability Status (Please mark all that apply)	
None	42
Yes. If yes, please specify (choose from list below):	
Difficulty Seeing	4
Difficulty hearing, or having speech understood	6
Mental Domain	5
Physical/Mobility Domain	11
Chronic Health Condition	5
Another disability not listed	1
Unknown/Decline to Answer	1

Veteran Status (Please mark only one choice)	
Yes	9
No	46
Unknown/Decline to Answer	25

OUTREACH. THIS SECTION IS *REQUIRED ONLY* FOR OUTREACH PROGRAMS. OTHERWISE, IT IS OPTIONAL

Number of potential responders: 374

List type of setting(s) in which the potential responders received outreach and the type(s) of potential responders engaged in each setting:

Type of Setting(s) (ex: school, place of worship, clinic)	**Type(s) of Potential Responders** (ex: principals, teachers, parents, nurses)
Senior Center	LGBTQ public, their peers, providers of older adult services
Non profit	LGBTQ public, their peers, providers of mental health and other social services
Coffee shop	LGBTQ activists & allies

NARRATIVE

a. Choose two of the above principles and describe how your program upholds or achieves those principles. Please speak to each principle separately and specifically describe how your program activities align with that corresponding principle.

Principle #1: Cultural Competence. How does your program align with this principle? We are continually looking at ways we can improve our cultural competence by hiring therapists who represent the LGBTQ community and are versed in how to approach each client and situation with cultural humility so that, even if the therapist or peer specialist doesn't share the values, customs and beliefs with one other or the other clients, each person is treated with respect and positive regard. At this time we are monolingual in our Older & Out program.

Principle #2: Wellness and Recovery. How does your program align with this principle? Our Older & Out groups are dedicated to promote resiliency and recovery in that the therapists and peer specialists don't dictate the topics for discussion or the goals for each client but instead use active listening skills to hear what topics they want to discuss and what goals they want to pursue.

b. Please tell us about the following…

i. Implementation Challenges: We continue to reach out to find people willing and able to facilitate the new peer groups in the East County, the groups that replaced the Older & Out Livermore therapy group while at the same time, pay attention to the chance that folks might want to have a therapy group in that region again. We also continue to watch for early signs of mental illness in group members with resources in place to make any needed referrals. We have developed a procedure on how to split a group into two smaller groups when the attendance is high, as often happens at the group located in Berkeley.

ii. Successes: Older &Out - Berkeley is very well attended, averaging 14 members. This creates a challenge and opportunity. The therapists and group members have a procedure on when and how they split into two rooms so that everyone has the opportunity to share. Outside of the Older & Out Berkeley group, community members are regularly socializing, led by 3 group members who are skilled at planning and bringing people together.

iii. Lessons Learned: Despite the low attendance at the Older & Out Hayward group, the current group members express the need for the group's presence at that senior center in that region, to continue to be visible to the

larger community and, in addition, express their appreciation for the opportunity to have access to therapy services.

iv. Relevant Examples of Success/Impact (e.g. a client success story) Reminder: Please do not use real client names: One Older & Out group members reported: "My expectations [of the group] were to bring out a side of me I have kept in the closest, hiding part of how I was, was really painful and hard. It [group] has allowed me a safe place to explore the part of me that has been taboo for most of my life except for [a] brief affair and childhood years when I was not yet afraid to express my gayness."

Additional Information

Please include the number of clients and/or contacts you estimate to serve in:

FY 19/20: We estimate we will serve 80 – 100 unduplicated clients.
FY 20/21: We estimate we will serve 80 – 100 unduplicated clients

Please tell us about any changes you intend to make to your program over the next two fiscal years and explain your rationale for making these changes: We are looking at expanding our outreach efforts, especially in East and Central County regions and also specifically to the queer and trans people of color in Alameda County to improve the attendance at our services provided in the East & Central regions of our county and to improve the attendance of queer and trans people of color in all our groups. We will be developing a short-term case management component to better meet the access, referral and linkage needs of our group members to improve the quality of their lives. We are increasingly aware from our therapists and peer specialists about the ways that the LGBTQ older adults are struggling.

Outreach for Increasing Recognition of Early Signs of Mental Illness PEI Data Report FY 18/19

MHSA Program Number: PEI 22
Program Name: Pacific Center Technical Assistance Program

This program provides cultural humility trainings to service providers in Alameda County. We provide both clinical and nonclinical trainings. Our trainings focus on how organizations can be more culturally responsive the LGBTQ+ community, both internally and externally.

GENERAL INFORMATION & TOTAL NUMBERS SERVED

Total Numbers Served through PEI MHSA			
Number of unduplicated individuals your program serves who are at-risk of developing a serious mental illness (SMI)	A		N/A
Number of unduplicated individuals your program serves who show early signs of forming a more severe mental illness	B		N/A
Number of unduplicated individual family members served indirectly by your program:	C		N/A
Grand TOTAL of unduplicated individuals served in the Quarter that you are reporting about. [This number (D) should = A=B+C.]	D		N/A

DEMOGRAPHICS

Age Group (Unduplicated)	
Children/Youth (0---15)	
Transition Age Youth (16---25)	
Adult (26---59)	
Older Adult (60+)	
Unknown/ Declined to Answer	X

Race (Please mark only one choice) *If Hispanic or Latino, choose "Another race not listed."*	
American Indian or Alaska Native	
Asian	
Black or African American	
Native Hawaiian or other Pacific Islander	
White	
More than one race	
Another race not listed	
Unknown/ Declined to Answer	X

Sexual Orientation (Please mark only one choice)	
Gay or Lesbian	
Heterosexual or Straight	
Bisexual	
Questioning or unsure of sexual orientation	
Queer	
Another sexual orientation not listed	
Unknown/Decline to Answer	X

Ethnicity /Cultural Heritage (Please mark only once choice)	
If Hispanic or Latino, please specify:	
Caribbean	
Central American	
Mexican/Mexican-American/Chicano	
Puerto Rican	
South American	
Another Hispanic/Latino ethnicity not listed	
Unknown/Declined to Answer	X
If Non-Hispanic or Non-Latino, please specify:	
African	
African American	
Asian Indian/South Asian	
Cambodian	
Chinese	
Eastern European	
European	
Filipino	
Japanese	
Korean	
Middle Eastern	
Vietnamese	
Other Non-Hispanic or Non-Latino ethnicity not listed	
More than one ethnicity	
Unknown /Declined to Answer	X

Primary Language (Please mark only one choice)	
English	
Spanish	
Farsi	
Cantonese	
Mandarin	
Other Chinese Dialects	
Vietnamese	
Korean	
Tagalog	
Other Filipino Dialect	
Japanese	
Laotian	
Cambodian	
Mien	
Hmong	
Samoan	
Thai	
Russian	
Polish	
German	
Italian	
Turkish	
Hebrew	
French	
Portuguese	
Armenian	
Arabic	
Sign ASL	
Other primary language not listed	
Unknown/ Decline to Answer	X

Gender Identity (Please mark both parts A & B)	
A) Assigned sex at birth: (Please mark only one choice)	
Male	
Female	
Other sex not listed (e.g. Intersex)	
Unknown/Decline to Answer	X
B) Current Gender Identity: (Please mark only one choice)	
Male	
Female	
Transgender	
Genderqueer	
Questioning or Unsure of Gender Identity	
Another Gender Identity not listed	
Unknown/Decline to Answer	X

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

REQUIRED STRATEGY: IMPROVE TIMELY ACCESS TO MENTAL HEALTH SERVICES FOR UNDERSERVED POPULATIONS

a. Who is/are the underserved target population/s your program is serving (e.g. TAY, Southeast Asian, etc.)?
LGBTQ+ Communities

b. Number of separate paper referrals to an ACBHCS PEI-funded program. (This can be a provider's internal ACBHCS PEI-funded prevention or early intervention program OR an external PEI-funded ACBHCS prevention or early intervention program): **N/A**

c. Number of individuals followed through on referral & engaged in an ACBHCS PEI-funded program: **N/A**

d. Average time in weeks between when a paper referral was given to individual by your program and the individual's first in person appointment with the ACBHCS PEI-funded provider. **N/A**

e. Describe ways your program encouraged access to services and follow-through on the above referrals: **N/A**

SECTION 5. OPTIONAL STRATEGY: OUTREACH FOR INCREASING RECOGNITION OF EARLY SIGNS OF MENTAL ILLNESS

Number of potential responders: 1 organization; 1 full-day conference; 10 facilitated workshops; 150 participants

List type of setting(s) in which the potential responders received outreach and the type(s) of potential responders engaged in each setting:

Type of Setting(s) (ex: school)	**Type(s) of Potential Responders** (ex: principals, teachers, parents, nurses)
Community Non-Profit	Executive Director, Program Manager, Direct Service Staff, Volunteers
Cal Endowment	Program Managers, Therapists, Social Workers, Students, Executive Directors

NARRATIVE

a. Choose two of the above principles and describe how your program upholds or achieves those principles. Please speak to each principle separately and specifically describe how your program activities align with that corresponding principle.

Principle #1: **Cultural Competence** How does your program align with this principle? The Technical Assistance Program provides LGBTQ+ cultural humility trainings to organizations working in Alameda County. We work with a variety of service providers, and offer both clinical and non-clinical trainings. Our trainings enable providers to interact with members of the LGBTQ+ community in a more culturally responsive, inclusive way. While our trainings focus on the challenges/needs facing the LGBTQ+ community, we also take intersectionality into consideration when tailoring our trainings. This means that we also consider the specific challenges of QTPOC within the larger framework of the LGBTQ+ community and beyond. To that end, The Pacific Center sponsored a day-long conference entitled, Mental Health at The Intersections.

This was our second such conference in two years. The focus was on the ways in which QTPOC can be better served by mental health practitioners and service providers. Workshop facilitators focused on the societal and personal traumas often faced by Trans/Non-Binary, Disabled POC, Immigrant and Intersex clients. They offered new frameworks for working with clients who identify in any of these groups, psycho-education, and specific cultural considerations. The conference was sold out and received positive feedback.

Principle #2: **Community Collaboration** How does your program align with this principle? The Technical Assistance Program Director works collaboratively with participating organizations to provide trainings that target specific service concerns as they relate to the LGBTQ+ community, and LGBTQ+ people of color. Pre-workshop assessments and site visits allow us to tailor each workshop to the particular needs, concerns, and/or challenges of each service provider. In addition to the workshops and evaluations themselves, we also offer collateral materials, such as handouts, articles and resource guides in order to support workshop participants with client needs that may be outside their immediate scope of practice.

Principle #3: **Wellness and Recovery** How does your program align with this principle? Under the TA Contract the Pacific Center also continued to offer grief and loss therapy groups to members of the LGBTQ+ community who are experiencing grief associated with loss. In this reporting period, 2, 8-week groups have been run, for a total of 16 unduplicated clients. (8 per group).

There was a change in leadership this quarter in that a new co -facilitators joined the group with the experienced, licensed therapist as a training ground for new clinicians. Group members worked on expressions of grief and building tolerance for painful emotions associated with loss, particularly anger, confusion, and despair. Members were invited to use weekly themes as a platform for exploring their grieving process and connecting with one another over shared experiences. Through expressions of compassion and empathy for one another, members were able to develop compassion and empathy for themselves.

b. Please tell us about the following…

i. Implementation Challenges: While we had one successful LGBTQ+ cultural humility training at the ABHCS offices, and planned for 3 others, we struggled to successfully complete all 4/one per quarter due to many factors. Our goal this fiscal year will be to complete at least three trainings at the county office.

ii. Successes: Pacific Center trainings were well attended and well received. Post-training evaluations indicated that workshop participants left with increased knowledge about the LGBTQ+ community (e.g. – terminology, life stressors, etc.) and concrete tools for engaging LGBTQ+ clients with more sensitivity. Additionally, The Pacific Center hosted a day-long conference on intersectional identities (see above section).

iii. Lessons Learned: Conducting follow-up trainings and/or trainings that are longer than the standard two hour training allows for deeper levels of participation, learning and integration of the material. Ideally, we would like to be able to provide tiered, or leveled, trainings for all of the organizations we collaborate with. This will allow us to move beyond "LGBTQ+ 101" and have a greater impact. Additionally, being aware of and integrating an intersectional framework consistently will allow us to reach a wider audience and have a greater impact.

iv. Relevant Examples of Success/Impact (e.g. a client success story) Reminder: Please do not use real client names: Our Mental Health at the Intersections conference had a deeply positive impact on the providers who attended. Many responded with statements such as:

"I will continue to deeply reflect on the shades & layers of privilege and oppression that I carry and that impact me personally and professionally." "I'll apply what I learned with my work with university student at a counseling center and with my volunteer community." "I really enjoyed Phoenix Jackson's presentation on complex PTSD and "mostly tool-less interventions" Theory DX Treatment very useful."

Evaluation Plan Update

a. Please describe, in 1-2 sentences, your effort to collect feedback from program participants (method used). Please include the timeframes of when you survey clients. Post-workshop evaluations are administered immediately following each workshop. Evaluations outline learning outcomes, and include both open ended questions and a 1-5 rating system in order to get a comprehensive overview of the levels of participant satisfaction.

b. Describe the tool (i.e. MHSIP or another survey) used to collect data. We use a paper evaluation developed by the Pacific Center. We also get qualitative input during post workshop conversations.

c. Summarize the results if any. In relation to our questions ranked 1-5, with 5 being the highest score, participants scored predominantly 4s & 5s across the following measurable categories: Met Learning Objectives, Instructor, Course Content, and Overall Satisfaction. The following quotes are representative of the majority sentiment expressed in answers to the open ended questions: "I have an increased sensitivity to issues facing my LGBTQ+ clients, specifically my transgender clients." "I have a better understanding of the difference between sexual orientation and gender expression." "I learned A LOT about ableism." "I have a more nuanced understanding of micro-aggressions." "This made me reflect on some micro-aggressions I may have used with clients." "I learned to not make assumptions based on appearance." "I need to recognize my own biases."

d. What was learned from the participant feedback (**1-2 key points**)? Overall we have received very positive feedback to date. The feedback reflects the need for introductory LGBTQ+ workshops, and also participants' desire for additional, follow-up workshops that are more in-depth and comprehensive. This is in alignment with Pacific Center training goals.

e. Describe how the findings were reviewed by staff**. Evaluation findings were reviewed by the Director of Diversity, Equity and Inclusion, and trainer(s).**

f. What programmatic change(s) were or will be adopted as a result of the findings? When will changes be made and how will the changes impact programming? The Program Director and trainers are actively encouraging partner agencies to pursue additional, deeper trainings via additional outreach, site visits and conversations. As of this reporting, one agency has devoted 3 consecutive PD trainings to LGBTQ+ concerns during Q1 of FY 2019-2020. Currently, the Pacific Center hosts one, full-day conference on intersectional identity markers and mental health. We would like to begin offering two of these conferences in FY 2020-2021 as a way to provide deeper, more integrated levels of learning around issues facing the LGBTQ+ communities of color. Finally, the Pacific Center allocated funds to expand the program coordinator's role to a director level. Along with working with outside agencies to increase cultural humility and awareness, the Director of Diversity, Equity and Inclusion (DEI) will also be charged with developing and implementing a comprehensive DEI strategy to address issues of inclusivity and equity within the organization's staffing, collateral materials and messaging, and across programs (eg – clinical training program, peer support group program, therapy group program).

g. What issues or challenges with the Evaluation Plan are you having? What technical assistance do you need? We are having a difficult time collecting demographic data consistently and comprehensively. Workshop participants are often reluctant to include such identifying information on their evaluations because the workshops happen in the context of work where hierarchical power dynamics are present.

Additional Information

Please include the number of clients and/or contacts you estimate to serve in:

FY 19/20: Our goal is to conduct 6 trainings per quarter, along with a day-long conference. Each quarter, our goal is for at least one partner organization to conduct scaffolded trainings.

FY 20/21: Our goal is to conduct 6 trainings per quarter, along with two, day-long conferences. Each quarter, our goal is for at least two partner organizations to conduct scaffolded trainings.

Please tell us about any changes you intend to make to your program over the next two fiscal years and explain your rationale for making these changes:

Access and Linkage to Mental Health Treatment Program
PEI Data Report FY 18/19

MHSA Program Number: PEI 1B
Program Name: School-Based Mental Health Access and Linkage in Elementary, Middle and High Schools

School-based Mental Health consultation and access and linkage program providing services in 14 of 18 Alameda County school districts. A partnership between ACBH and the Center for Healthy Schools and Communities (CHSC). Coordination of service teams (COST) help refer and connect students to prevention and early intervention or treatment services.

GENERAL INFORMATION & TOTAL NUMBERS SERVED

Total Numbers Served through PEI MHSA		
Number of unduplicated individuals your program serves who are **at-risk** of developing a mental health problem or serious mental illness (SMI)	A	15,833
Number of unduplicated individuals your program serves who show **early signs** of forming a more severe mental illness	B	8,732
Number of unduplicated individual family members served indirectly by your program:	C	0
Grand TOTAL of unduplicated individuals served in the Quarter that you are reporting about. [This number (D) should = A+B+C.]	D	24,565

DEMOGRAPHICS

Age Group (Unduplicated)	
Children/Youth (0-15)	
Transition Age Youth (16-25)	
Adult (26-59)	
Older Adult (60+)	
Unknown/ Declined to Answer	15,833

Race (Please mark only one choice) *If Hispanic or Latino, choose "Another race not listed."*	
American Indian or Alaska Native	226
Asian	2,013
Black or African American	2,677
Native Hawaiian or other Pacific Islander	248
White	1,969
More than one race	676
Another race not listed	5,646
Unknown/ Declined to Answer	627

Sexual Orientation (Please mark only one choice)	
Gay or Lesbian	40
Heterosexual or Straight	385
Bisexual	3
Questioning or unsure of sexual orientation	5
Queer	0
Another sexual orientation not listed	1
Unknown/Decline to Answer	9,678

Ethnicity /Cultural Heritage (Please mark only once choice)	
If Hispanic or Latino, please specify:	
Caribbean	1
Central American	30
Mexican/Mexican--American/Chicano	507
Puerto Rican	1
South American	18
Another Hispanic/Latino ethnicity not listed	202
Unknown/Declined to Answer	4,141
If Non-Hispanic or Non-Latino, please specify:	
African	48
African American	541
Asian Indian/South Asian	392
Cambodian	20
Chinese	245
Eastern European	12
European	41
Filipino	300
Japanese	20
Korean	22
Middle Eastern	64
Vietnamese	65
Other Non-Hispanic or Non-Latino ethnicity not listed	343
More than one ethnicity	1,689
Unknown /Declined to Answer	1,998

Primary Language (Please mark only one choice)	
English	6,309
Spanish	2,626
Farsi	56
Cantonese	115
Mandarin	111
Other Chinese Dialects	19
Vietnamese	79
Korean	12
Tagalog	68
Other Filipino Dialect	6
Japanese	14
Laotian	7
Cambodian	32
Mien	15
Hmong	1
Samoan	2
Thai	3
Russian	9
Polish	1
German	0
Italian	0
Turkish	4
Hebrew	0
French	13
Portuguese	3
Armenian	2
Arabic	148
Sign ASL	4
Other primary language not listed	566
Unknown/ Decline to Answer	5,865

Gender Identity	
A) Assigned sex at birth: (Please mark only one choice)	
Male	6,035
Female	4,869
Other sex not listed (e.g. Intersex)	54
Unknown/Decline to Answer	5,015
B) Current Gender Identity: (Please mark only one choice)	
Male	1,704
Female	1,370
Transgender	4
Genderqueer	0
Questioning or Unsure of Gender Identity	0
Another Gender Identity not listed	1
Unknown/Decline to Answer	7,000

Disability Status (Please mark all that apply)	
None	964
Yes. If yes, please specify (choose from list below):	
Difficulty Seeing	7
Difficulty hearing, or having speech understood	236
Mental Domain	255
Physical/Mobility Domain	5
Chronic Health Condition	692
Another disability not listed	917
Unknown/Decline to Answer	8,851

Veteran Status (Please mark only one choice)	
Yes	
No	
Unknown/Decline to Answer	15,833

REQUIRED STRATEGY: INCREASE ACCESS AND LINKAGE TO MENTAL HEALTH TREATMENT

a. Number of individuals with serious mental illness (SMI) who received a paper referral (i.e. referrals via phone do not apply) from your program to an ACBHCS mental health treatment program: 4,780 individuals

b. List type(s) of mental health treatment programs the individual was referred to: Mental health treatment programs that individuals were referred to primarily consisted of the following school-based health services: individual counseling or therapy, group counseling, crisis intervention, individualized behavior support, family counseling and parent workshops. Additionally, linkages to other services outside of school-based health resources were made when needed.

c. Number of individuals who were successfully referred and linked to an ACBHCS mental health treatment program (i.e. client has been seen at least once in person by a treatment provider): 4,837

d. Average duration in weeks of signs of untreated mental illness (per client self-report): n/a

e. Average time in weeks between when a paper referral was given to individual by your program and the individual's first in person appointment with a mental health treatment provider: The average time in weeks between when a paper referral was given to an individual and when that individual had their first appointment with a mental health treatment provider varied across the 14 school districts receiving MHSA funding support. Below is a table with the average times of referral to first appointment by district.

School District	*Average Time between Referral and Treatment*
Alameda USD	1-2 weeks
Castro Valley USD	1-2 weeks
Emeryville USD	1-2 weeks
Fremont USD	3-4 weeks
Hayward USD	3-4 weeks
Livermore USD	3-4 weeks
New Haven USD	3-4 weeks
Newark USD	3-4 weeks
Oakland USD	2-4 weeks
Piedmont USD	3-4 weeks
Pleasanton USD	1-2 weeks
San Leandro USD	3-4 weeks
San Lorenzo USD	3-4 weeks

f. Any additional information to report on? (Optional): n/a

REQUIRED STRATEGY: IMPROVE TIMELY ACCESS TO MENTAL HEALTH SERVICES FOR UNDERSERVED POPULATIONS

a. Who is/are the underserved target population/s your program is serving (e.g. TAY, Southeast Asian, etc.)?
- Transitional-aged youth
- Foster youth
- LGBTQ-identifying youth
- Boys and young men of color
- Unaccompanied immigrant youth
- Food and shelter insecure youth and families
- English as a second language youth

b. Number of separate paper referrals to an ACBHCS PEI-funded program. (This can be a provider's internal ACBHCS PEI-funded prevention or early intervention program OR an external PEI-funded ACBHCS prevention or early intervention program):

A majority of referrals are primarily to school-based mental health treatment with service providers that collaborate with the schools. Given that only a minority of paper referrals are to an ACBHCS PEI-funded programs, we do not separate ACBHCS PEI-funded and non-funded referrals in our data collection process.

c. Number of individuals followed through on referral & engaged in an ACBHCS PEI-funded program: n/a

d. Average time in weeks between when a paper referral was given to individual by your program and the individual's first in person appointment with the ACBHCS PEI-funded provider. n/a

e. Describe ways your program encouraged access to services and follow-through on the above referrals:
Alameda County School Districts are implementing a Coordination of Services Team (COST) strategy to increase early identification of students who may need support services as well as access and linkage to behavioral and mental health care. Through COST implementation teachers, staff, students (self-referral) and families may submit referrals for students they are concerned about and a multidisciplinary group of staff and internal/external service providers (i.e. COST Team) meets weekly or biweekly to triage student needs. During COST team meetings, members take responsibility for following up with the student and their guardian to ensure linkage to care is offered. Furthermore, the COST coordinator documents when follow-up occurred, if linkage to care was accepted, and the initiation date of the care that the student received.

f. Any additional information to report on (optional): n/a

NARRATIVE

a. Choose two of the above principles and describe how your program upholds or achieves those principles. Please speak to each principle separately and specifically describe how your program activities align with that corresponding principle.

Principle #1: Client, Consumer, and Family Involvement
How does your program align with this principle?

Emphasis on client, consumer and family involvement is high across each Alameda County school district that CHSC supports. All of the schools implement a service model that prioritizes clients, consumers and families in all aspects of the mental health system from planning and service delivery to evaluation and policy development.

Service plans are created in collaboration with the client and/or caregiver(s) as well as teachers and other key individuals in order to ensure that the services they receive reflects their goals and needs. In addition, an informed consent process is always provided to students and their families when they are being referred to a service.

Furthermore, many Alameda County school districts collaborate with multiple parent organizations and committees (i.e. PTAs, ELACs, SSCs, Parent Leadership Councils, etc.) to gather input on how to best serve students and their families.
As a result some schools have increased Wellness Centers within their districts, hosted regular parent cafes that provide caregivers a space where they can speak openly with school administrators, presented at family partnership events, and included parents their special education strategic planning processes.

Principle #2: Integrated Service Delivery ,How does your program align with this principle?

Implementation of a Coordination of Services Team (COST) strategy utilizes a diverse team of school staff and representatives from service providers to take a holistic approach to assessing student needs, integrating internal and external support services and linking students and/or their families to the appropriate support system.

COST has been integral to increasing and streamlining service delivery to students throughout Alameda County. Districts have noted that the cross-site integration of students transitioning from either elementary to middle school or middle to high school supports the continuity of care for students, especially those with the highest needs, while also preparing the receiving site with information in advance that allows them to better serve transitioning students and their families. Collaboration between schools and behavioral and mental health service providers (whether internal or external) is continuously encouraged and many of the districts are in the process of developing or integrating the implementation of their COST model to work in tandem with their Positive Behavior Interventions and Support programming as well as their Multi-tiered Systems of Support Strategies.

b. Please tell us about the following…

i. Implementation Challenges:

- Many of our school-based services are primarily for Medi-Cal eligible individuals. At times, it can be challenging to quickly link students the appropriate service either due to high volumes of individuals who are ineligible for Medi-Cal or limited availability of resources that they are eligible for. However, implementation of COST has allowed us to triage students' needs and decrease the duration of time between when a student is identified as potentially being in need, assessed, and connected to a service provider.

- Successful implementation of the COST model is contingent upon support from district and site-level leadership as it cultivates "buy-in" from the rest of the school staff. When school sites change Principals and COST coordinators, the Center for Healthy Schools and Communities usually has to establish new relationships and orient new leadership to the COST model. During times of district turnover, it can be challenging to streamline the process of connecting students to behavioral health care services as new leadership acclimates to the COST model.

- As many districts are seeing changes in their population's demographics, especially those that historically have not had many students of color and/or unaccompanied immigrant youth, they have to reassess the services they provide to their students. This includes increased trainings on trauma awareness, cultural competency, and restorative practices – all of which often takes time and capacity that not all schools have.

ii. Successes:

- More schools have reported training their staff and adopting restorative practices at their sites. Restorative Practices are a form of student support that focus on improving relationships and community over punitive actions. Given that students of color are often disproportionately suspended, restorative practices provide an alternative to suspension and an avenue to identify students who may need mental health treatment. Another success and positive impact of the implementation of COST among Alameda County schools is the expansion of Restorative Practices training and programming.

- Over the last academic year both COST referrals and linkage to care have increased across all 14 CHSC supported school districts. In addition, duration of time between referrals and connection to services has decreased at most districts.

iii. Lessons Learned:
Establishing relational trust and buy-in of strategies and services with new district leadership and staff members is vital to increased implementation and uptake of mental health treatment services for students and their families. CHSC continuously strives to establish and maintain positive relationships with school districts as well as to foster positive relationships between schools and service providers.

iv. Relevant Examples of Success/Impact (e.g. a client success story) Reminder: Please do not use real client names:
Mike, an elementary school student, was referred to COST after teachers reported he was chronically absent and further investigation discovered he had an attendance rate of 51%. The school's attendance social worker contacted Mike's mother and discovered that the Mike had an older sibling who suffered from a mental illness and had begun enacting on threats previously made to harm their family. Both Mike and his mother were exhibiting PTSD symptoms, which is why Mike had been missing school. The social worker connected the family to an outside provider that was able to place his sibling in a residential treatment program, connected Mike to a therapist, connected Mike's mother to Victims of Crime services, and met with both parents to come to an agreement that Mike would live with his father because he had a more stable schedule and could take Mike to school every day. Mike currently sees a therapist weekly and has made drastic improvements including depicting happiness, participating in school events, and his attendance rate has increased to 87%.

Additional Information

Please include the number of clients and/or contacts you estimate to serve in:
FY 19/20: 26,500
FY 20/21: 29,000

Stigma and Discrimination Reduction
PEI Data Report FY 18/19

MHSA Program Number: PEI 4
Program Name: Stigma and Discrimination Reduction Campaign-Everyone Counts Campaign (EEC)- PEERS

The EEC aims to reduce stigma and discrimination against people with mental health challenges and promotes social inclusion through three strategies: Empowerment (Healing Arts and Spirituality Groups), Outreach (Lift Every Voice and Speak, Action Teams, Outreach and Communications (website, email, social media).

General Information & Total Numbers Served

Total Numbers Served through PEI MHSA		
Number of unduplicated individuals your program serves who are **at-risk** of developing a mental health problem or serious mental illness (SMI)	A	241
Number of unduplicated individuals your program serves who show **early signs** of forming a more severe mental illness	B	
Number of unduplicated individual family members served indirectly by your program:	C	
Grand TOTAL of unduplicated individuals served in the Quarter that you are reporting about. [This number (D) should = A+B+C.]	D	241

*Totals do not include email, outreach events, or community presentations/speaking engagements where people do not sign in

List Number of Individuals Reached by each Activity (ex: who accessed website, social media hits, tabling/outreach events, e-blasts, etc.): Click here to enter text.

Type of Activity (ex: accessed website)	**Number of Individuals Reached** (#)
Email blasts of ECC-related articles and updates	2,495 subscribers
ECC Communications: Hard copy calendar updates	8,000 est. reached
African American ECC focus groups and Action Team meetings	29
Special Messages groups	49
Spirituality groups	30
Lift Every Voice and Speak (LEVS) speaking engagements	396
Tabling/outreach events	1,600 (approximately)
Community presentations	219

DEMOGRAPHICS

Age Group (Unduplicated)	
Children/Youth (0-15)	
Transition Age Youth (16-25)	21
Adult (26-59)	101
Older Adult (60+)	25
Unknown/ Declined to Answer	94

Race (Please mark only one choice) *If Hispanic or Latino, choose "Another race not listed."*	
American Indian or Alaska Native	
Asian	5
Black or African American	108
Native Hawaiian or other Pacific Islander	
White	40
More than one race	17
Another race not listed	30
Unknown/ Declined to Answer	41

Sexual Orientation (Please mark only one choice)	
Gay or Lesbian	
Heterosexual or Straight	38
Bisexual	2
Questioning or unsure of sexual orientation	
Queer	
Another sexual orientation not listed	2
Unknown/Decline to Answer	199

Ethnicity /Cultural Heritage (Please mark only once choice)	
If Hispanic or Latino, please specify:	
Caribbean	
Central American	
Mexican/Mexican--American/Chicano	3
Puerto Rican	
South American	
Another Hispanic/Latino ethnicity not listed	
Unknown/Declined to Answer	17
If Non-Hispanic or Non-Latino, please specify:	
African	1
African American	108
Asian Indian/South Asian	1
Cambodian	0
Chinese	1
Eastern European	0
European	3
Filipino	3
Japanese	1
Korean	0
Middle Eastern	1
Vietnamese	0
Other Non-Hispanic or Non-Latino ethnicity not listed	3
More than one ethnicity	3
Unknown /Declined to Answer	89

Primary Language (Please mark only one choice)	
English	58
Spanish	7
Farsi	
Cantonese	1
Mandarin	
Other Chinese Dialects	
Vietnamese	
Korean	
Tagalog	
Other Filipino Dialect	
Japanese	
Laotian	
Cambodian	
Mien	
Hmong	
Samoan	
Thai	
Russian	
Polish	
German	
Italian	
Turkish	
Hebrew	
French	
Portuguese	
Armenian	
Arabic	
Sign ASL	
Other primary language not listed	1
Unknown/ Decline to Answer	174

Gender Identity (Please mark both parts A & B)	
A) Assigned sex at birth: (Please mark only one choice)	
Female	
Other sex not listed (e.g. Intersex)	
Unknown/Decline to Answer	241
B) Current Gender Identity: (Please mark only one choice)	
Male	92
Female	108
Transgender	
Genderqueer	
Questioning or Unsure of Gender Identity	
Another Gender Identity not listed	1
Unknown/Decline to Answer	40

Disability Status (Please mark all that apply)	
None	0
Yes. If yes, please specify (choose from list below):	
Difficulty Seeing	
Difficulty hearing, or having speech understood	
Mental Domain	19
Physical/Mobility Domain	9
Chronic Health Condition	
Another disability not listed	
Unknown/Decline to Answer	213

Veteran Status (Please mark only one choice)	
Yes	4
No	56
Unknown/Decline to Answer	181

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

REQUIRED STRATEGY: IMPROVE TIMELY ACCESS TO MENTAL HEALTH SERVICES FOR UNDERSERVED POPULATIONS

a. Who is/are the underserved target population/s your program is serving (e.g. TAY, Southeast Asian, etc.)? Mental health consumers, primarily low-income people of color, including TAY and older adults.

b. Number of separate paper referrals to an ACBHCS PEI-funded program. (This can be a provider's internal ACBHCS PEI-funded prevention or early intervention program OR an external PEI-funded ACBHCS prevention or early intervention program): 1

c. Number of individuals followed through on referral & engaged in an ACBHCS PEI-funded program: 0

d. Average time in weeks between when a paper referral was given to individual by your program and the individual's first in person appointment with the ACBHCS PEI-funded provider. N/A The referrals were not for "appointments" per se. One participant, who has a TAY-aged child struggling with mental health challenges, was referred to Intensive Home Outreach Team (IHOT). Other referrals were to programs not funded by ACBH PEI, such as 2-1-1 for the Consolidated Entry System. For example, we provided one participant with referrals to Bay Legal's Alameda County Tenants' Rights Hotline (and 2-1-1) for advice on negotiating with his landlord and he was able to avoid eviction.

e. Describe ways your program encouraged access to services and follow-through on the above referrals: Our primary method is to provide both information about participants' options and personal encouragement, since self-determination is a core principle of our program model.

NARRATIVE

a. Choose two of the above principles and describe how your program upholds or achieves those principles. Please speak to each principle separately and specifically describe how your program activities align with that corresponding principle.

Principle #1: Cultural Competence. How does your program align with this principle? PEERS has provided culturally competent services with cultural humility for African Americans with mental health challenges for many years. One example of our practice of cultural competence is our African American Everyone Counts Campaign. FY18-19 was the planning year for this campaign, which builds on PEERS' Latino Everyone Counts Everyone Counts Campaign (FY16-17 and FY17-18) and Chinese American Everyone Counts Campaign (FY14-15 and FY15-16). The campaign is staffed and led by African Americans, all of whom have lived experience with mental health challenges. Some elements of African American culture that have been incorporated into the planning of the campaign include taking a trauma-informed approach, incorporating culturally-informed ritual into meetings and other gatherings, and making room for talking about religion and belief systems, as well as shared histories of oppression and current experiences of racism. The campaign is guided by an African American Action Team, composed of a diverse group of 16 African American community members with lived experience of mental health challenges. One of Action Team's charges this year was to identify a group with the power and influence to reduce stigma around mental health in the local African American community. The Action Team decided that people in the music and entertainment industries have that kind of influence. We are in the process of recruiting influential artists and media producers to the campaign, including Mistah Fab, So Oakland, and KPFA.

Principle #2: Wellness and Recovery. How does your program align with this principle? All of the community outreach (both in-person and online) PEERS does through the Everyone Counts Campaign is strongly grounded in messages of wellness and recovery. From our "Love More, Judge Less" t-shirts, to our insistence on using non-stigmatizing recovery-based language instead of diagnostic or symptom-focused language, to the many ways that our staff act as living models of the possibility of wellness and recovery, PEERS aligns with this principle consistently. Our Lift Every Voice and Speak speakers' bureau (LEVS), promotes wellness and recovery by training people with lived experience of mental health challenges to tell their recovery stories, including how different forms of stigma have affected them. By telling their stories, LEVS speakers introduce wellness and recovery perspectives to audiences of other mental health consumers as well as to community members who may not have similar experiences. The speakers' bureau enhances the wellness of LEVS

speakers themselves by building supportive peer relationships, developing leadership, and improving their community by reducing stigma.

b. Please tell us about the following…

i. Implementation Challenges: At the beginning of FY18-19, attendance at LEVS meetings was lower than we wanted, with an average attendance of eight participants during the first quarter. To increase engagement, we revamped the meetings and the speaker training curriculum. We incorporated more healing and wellness tools into the meetings, including art activities and small-group sharing. The program coordinator implemented a new system for supporting each speaker to move toward her or his own speaking goals. We also brought more structure to the speaker trainings, so that members were better able to support each other to improve their effectiveness as speakers. Additional training on the different forms of stigma related to mental health challenges (public stigma, structural stigma, and self stigma) also deepened speakers' ability to link their personal stories to stigma reduction. On another note, at the end of FY17-18, we redesigned our spirituality program to emphasize facilitating groups at other places where people gather rather than at PEERS, because we were not satisfied with the level of attendance at our spirituality groups. To that end, we developed a new partnership with Allen Temple Arms, an affordable housing complex for low-income seniors and people with disabilities. Not only were the spirituality groups well received by the residents, but PEERS' partnership with Allen Temple Arms expanded beyond the spirituality program.

ii. Successes: The African American Everyone Counts Campaign has had some major successes in getting media coverage. In July, Bre Williams, PEERS' Programs Manager, was featured on an hour-long show on KPFA radio that explored questions including what it means to be mentally and emotionally healthy, why mental, emotional, and physical health often are understood as separate, how dominant cultural norms frame understanding of health and illness -- and more healthful and culturally relevant ways to understand mental health. In November, PEERS' Executive Director Vanetta Johnson along with staff members Bre Williams and Ashlee Jemmott were featured on the KBLX radio show "Listen Up Bay Area," which features local organizations. In a 15-minute segment, they discussed key themes related to mental health among African Americans, including the goals of the African American Everyone Counts Campaign. In the spring, the campaign was again featured on KPFA during KPFA's coverage of Oakland's Juneteenth celebration. As for Lift Every Voice and Speak, the changes to the speakers' bureau program were so successful that by the fourth quarter, average attendance at meetings increased to 18 and membership increased to 30. The program currently is at capacity and we have suspended recruitment of new members.

iii. Lessons Learned: During the planning phase for the two-year African American Everyone Counts Campaign, PEERS held a series of focus groups -- one for high-school aged young men, one for high-school aged young women, and one for elders. Each group discussed what they need in their neighborhoods to thrive and be successful; what cultural competency means to them; what supports, skills, and resources they need in order to develop healthier self-esteem; and what would help them be more prepared to respond to the daily stressors associated with racism, discrimination, and other forms of systematic oppression. Themes that emerged in all three groups included attention to the social determinants of health such as the need for good jobs, access to healthy food and grocery stores, role models, and support (e.g. "Neighborly love - someone to talk to about real stuff."). Young women strongly expressed the need for safety in many settings, especially safety from physical and sexual violence. Young men talked about needing to know more about their history and the histories of their people. When discussing cultural competency, focus group participants articulated the need to be understood. One young woman said, "Doctors need to be aware of black people's humanity." An elder participant pointed out, "Not all black people are the same." Another elder participant described how, as a black man, he has to set his mental health providers at ease and make the provider feel comfortable in order to get services. As we move into the next stage of the campaign, we will incorporate what we have heard so far, and continue to seek out the insights of more African American community members.

iv. Relevant Examples of Success/Impact (e.g. a client success story) Reminder: Please do not use real client names: The LEVS speakers' bureau program coordinator implemented a new system for supporting each speaker to move toward her or his own goals. At the beginning of the year, or upon joining LEVS, each speaker is given the option of setting an individual goal. The program coordinator then adapts the curriculum and designs opportunities to assist each participant to pursue their goal. LEVS participants recently described the group as "a speakers' bureau for healers," and "a healing community that helps spread hope." One member of the speakers' bureau said that she now is "speaking in a voice I didn't know I had."

ADDITIONAL INFORMATION

Please include the number of clients and/or contacts you estimate to serve in:

FY 19/20: 275 (does not include email, outreach events, or community presentations/speaking engagements where people do not sign in)

FY 20/21: 275 (does not include email, outreach events, or community presentations/speaking engagements where people do not sign in)

Please tell us about any changes you intend to make to your program over the next two fiscal years and explain your rationale for making these changes: The two primary changes to PEERS ECC programs in the next two years will be in the ethnic-specific social inclusion campaigns and in the program's Anti-Stigma Latino (PAL). In FY 19-20, we will move from planning to implementation of the African American Everyone Counts Campaign, which includes facilitating two multi-session stigma reduction support groups. In FY 20-21, we expect to be in a planning year for another culture-specific Everyone Counts Campaign. In FY 19-20, we also will begin implementation of PAL, a Latino-focused anti-stigma program that will include peer support groups and community presentations.

Suicide Prevention PEI Data Report FY 18/19

MHSA Program Number: PEI 12
Program Name: Suicide Prevention- Crisis Support Services of Alameda County Text Line Program

Offer the ability for Alameda County residents – emphasis on youth and young adults – to contact the Crisis Line via text message between 4pm – 11pm 7 days a week: Text "SAFE" to 20121. Free crisis texting for suicide prevention.

General Information & Total Numbers Served

Total Numbers Served through PEI MHSA		
Number of unduplicated individuals your program serves who are **at-risk** of developing a mental health problem or serious mental illness (SMI)	A	333
Number of unduplicated individuals your program serves who show **early signs** of forming a more severe mental illness	B	
Number of unduplicated individual family members served indirectly by your program:	C	
Grand TOTAL of unduplicated individuals served in the Quarter that you are reporting about. [This number (D) should = A+B+C.]	D	333

NOTE: Because this is a text crisis line we have limited ability to get much general information during a crisis conversation, and we do not have enough contextual information to accurately report on individuals showing signs of forming a mental illness later. Therefore we categorize all unduplicated individuals as "at risk". We do know that the symptoms expressed combined with the crisis situation could create "risk for SMI" for individuals.

435 individuals contacted our Text Line Program. Not all had a text session – often individuals will opt in to the program during off hours to test the system out in case they want to use it in the future. 333 individuals had text sessions with counselors.

List Number of Individuals Reached by each Activity (ex: who accessed website, social media hits, tabling/outreach events, e-blasts, etc.): Click here to enter text.

Type of Activity (ex: accessed website)	**Number of Individuals**
Opting in to the program but not having a text session – usually off hours – to try it out	102
Opting in and had text session	333

Offer the ability for Alameda County residents – emphasis on youth and young adults – to contact the Crisis Line via text message between 4pm – 11pm 7 days a week: Text "SAFE" to 20121. The service is free. Most major cell carriers do not charge their customers to text to 20121.	435
Engage in text sessions – reaching individuals who prefer to text rather than to talk to a counselor	1115 text sessions with 333 individuals

DEMOGRAPHICS

Age Group (Unduplicated)	
Children/Youth (0-15)	115
Transition Age Youth (16-25)	21
American Indian or Alaska Native	
Asian	2
Black or African American	
Native Hawaiian or other Pacific Islander	2
White	2
More than one race	
Another race not listed	
Unknown/ Declined to Answer	

Gender Identity (Please mark both parts A & B)	
A) Assigned sex at birth: (Please mark only one choice)	
Male	
Female	
Other sex not listed (e.g. Intersex)	
Unknown/Decline to Answer	
B) Current Gender Identity: (Please mark only one choice)	
Male	26
Female	92
Transgender	2
Genderqueer	
Questioning or Unsure of Gender Identity	6
Another Gender Identity not listed	
Unknown/Decline to Answer	

Ethnicity /Cultural Heritage (Please mark only once choice)	
If Hispanic or Latino, please specify:	
Caribbean	
Central American	
Mexican/Mexican--American/Chicano	
Puerto Rican	
South American	
Another Hispanic/Latino ethnicity not listed	
Unknown/Declined to Answer	
If Non-Hispanic or Non-Latino, please specify:	
African	
African American	
Asian Indian/South Asian	
Cambodian	
Chinese	
Eastern European	
European	
Filipino	
Japanese	
Korean	
Middle Eastern	
Vietnamese	
Other Non-Hispanic or Non-Latino ethnicity not listed	
More than one ethnicity	
Unknown /Declined to Answer	

Primary Language (Please mark only one choice)	
English	
Spanish	
Farsi	
Cantonese	
Mandarin	
Other Chinese Dialects	
Vietnamese	
Korean	
Tagalog	
Other Filipino Dialect	
Japanese	
Laotian	
Cambodian	
Mien	
Hmong	
Samoan	
Thai	
Russian	
Polish	
German	
Italian	
Turkish	
Hebrew	
French	
Portuguese	
Armenian	
Arabic	
Sign ASL	
Other primary language not listed	
Unknown/ Decline to Answer	

Sexual Orientation (Please mark only one choice)	
Gay or Lesbian	2
Heterosexual or Straight	
Bisexual	3
Questioning or unsure of sexual orientation	
Queer	
Another sexual orientation not listed	
Unknown/Decline to Answer	

Disability Status (Please mark all that apply)	
None	
Yes. If yes, please specify (choose from list below):	
Difficulty Seeing	
Difficulty hearing, or having speech understood	
Mental Domain	
Physical/Mobility Domain	
Chronic Health Condition	
Another disability not listed	
Unknown/Decline to Answer	

Veteran Status (Please mark only one choice)	
Yes	
No	
Unknown/Decline to Answer	

REQUIRED STRATEGY: IMPROVE TIMELY ACCESS TO MENTAL HEALTH SERVICES FOR UNDERSERVED POPULATIONS

a. Who is/are the underserved target population/s your program is serving (e.g. TAY, Southeast Asian, etc.)? Middle to high school students in Alameda County. We can also serve TAY and adults, but our target population are school age people.

b. Number of separate paper referrals to an ACBHCS PEI-funded program. (This can be a provider's internal ACBHCS PEI-funded prevention or early intervention program OR an external PEI-funded ACBHCS prevention or early intervention program): N/A

c. Number of individuals followed through on referral & engaged in an ACBHCS PEI-funded program: N/A

d. Average time in weeks between when a paper referral was given to individual by your program and the individual's first in person appointment with the ACBHCS PEI-funded provider. N/A

e. Describe ways your program encouraged access to services and follow-through on the above referrals: N/A *although much of our crisis management is to help texters think through their next steps in staying safe and often includes discussion of who in their life they might help them to access mental health support access.

NARRATIVE

a. Choose two of the above principles and describe how your program upholds or achieves those principles. Please speak to each principle separately and specifically describe how your program activities align with that corresponding principle.

Principle #1: Cultural Competence . How does your program align with this principle? Click here to enter text.
The last two years we have lowered the age requirement to be trained as a text line counselor. This means that the youngest volunteers have been 19 years old. The younger cohort of volunteers has helped all of us to understand the people we are serving better as well as enlivened our conversations during training as we sift through assumptions and other misunderstandings that can occur between older adults and youth. We have also had more understanding of the nature of the online lives of youth from our younger counselors.

Principle #2: Wellness and Recovery How does your program align with this principle? In each text session we try to accomplish a post text care plan. Sometimes this can look like discussing what music the texter will listen to, or their homework assignments, or more involved post text care involving safety planning. In all these conversations we are building in an awareness of texter's own self efficacy and personal wellness tools. We often share a pdf created by Your Life Your Voice, 99 coping tools, and discuss which items the texter resonates with. We also share a Safety Planning template from Your Life Your Voice or the My3app.org. In all these instances, the main goal is to affirm the texter's own sense of agency and explore ways to take care of their emotional needs.

b. Please tell us about the following…

i. Implementation Challenges: Texts take a long time. Often if we do not have proper staffing we are unable to adequately answer the incoming texts. On the other hand, there are times when we are not getting that many texts because we need to expand our outreach – but there is not enough staffing to do this as the current staff is focusing on training and being a responder.

ii. Successes: It is amazing the wonderful and expert counseling that trainees and volunteers and other staff can accomplish without letters after their names. The quality of care is constantly being attended to, and texters often express their gratitude. "Thank you so much for talking to me. You made me feel really comfortable, and I actually wish I'd done this sooner, lol. Thank you!"

iii. Lessons Learned: We are continually challenged with building rapport and asking assessment questions. What we have found over time is that assessment questions paired with empathic statements can be successfully integrated in to a session. We also have grown in our ability to be "transparent" about the counselor's experience texting with such messages such as "I'm hearing that today things are ok, and so I hope it's not weird that I'm asking this, but even when people are doing great they sometimes think about dying. I'm wondering have you been experiencing any thoughts of suicide lately?"

iv. Relevant Examples of Success/Impact (e.g. a client success story) Reminder: Please do not use real client names: We engaged in several emergency rescues this year where the texter felt comfortable enough to text us and let us know they had acted on their suicidal ideation and did not believe they would be able to stay safe.

ADDITIONAL INFORMATION

Please include the number of clients and/or contacts you estimate to serve in:

FY 19/20: 1115
FY 20/21: 1115

Please tell us about any changes you intend to make to your program over the next two fiscal years and explain your rationale for making these changes: We need to find a way to increase our capacity to take texts. They are longer than taking phone calls, however sometimes we can take more than one text at a time. Increase training modules that focus on youth related issues.

C. INNOVATIVE (INN) PROGRAM SUMMARIES

Innovations Programs are intended to provide mental health systems with an opportunity to learn from innovative approaches. Innovations Programs are not designed to support existing or ongoing programs or services, but rather to provide the mental health system with innovative demonstration projects that will support system change in order to increase access to services and improve client/consumer outcomes.

An Innovations Project may introduce a novel, and/or ingenious approach to a variety of mental health practices. Innovations Projects can contribute to learning at any point across the spectrum of an individual or family's needs relating to mental health, from prevention and early intervention to recovery supports which includes supportive housing.

An Innovative Project must meet the following criteria:

1. It is new, meaning it has **not** previously been done in the mental health field;
   Innovation Projects must promote new approaches to mental health in one or more of the following ways:

   - Introducing a new mental health practice or approach, or
   - Adapting an existing mental health practice or approach, so that it can serve a new target population or setting, or
   - Modifying an existing practice or approach from another field, to be used for the first time in mental health.

2. It has a learning component, which will contribute to the body of knowledge about mental health.

   - The learning component is represented in the application's Learning Question.

Before Innovation funds can be spent on an Innovation project, the project idea must be vetted through a 30 day public review process, approved by the County Board of Supervisors and then approved by the Mental Health Services Oversight and Accountability Commission (MHSOAC). The first two steps may take place as part of a Three year Plan or Plan Update or may be implemented as a stand-alone process.

Summary of Changes

1. INN Programs under Approval Process

A. Funding for Community Planning Process And Stakeholder Input

Alameda County Behavioral Health (ACBH) continues to be fully invested in having a dynamic community process that is inclusive of all communities with the County. Community involvement from the residents of the county is essential to Innovation planning and program development. ACBH has had challenges in its outreach to many of its diverse populations. These challenges include outreach and engagement to unserved and underserved individuals in both urban and rural areas. The County is dedicated to developing a revitalized and improved approach to ensure more meaningful input from all individuals living in the county.

Alameda County is requesting to use Innovation funds for fixed annual allocation for community planning activities involving stakeholders, especially individuals in unserved and underserved communities of the county. This annual allocation will be specific in its support of design, development,

and implementation of Innovations ideas brought forth through the community planning process. Presently, under MHSA regulations, counties may use up to 5% of their total MHSA Innovation budgets to fund community program planning, and designate positions for oversight and support.

The County is seeking approval from the Mental Health Services Oversight and Commission to utilize a total of $750,000 ($150,000 per year) over the next five (5) years to conduct innovation-related community planning. These funds will be dedicated to redesigning a more informed, community planning process that will allow the County to revitalize its current process.

Additionally, as part of ACBH's plan, a dedicated Innovations Coordinator has been added to the County's MHSA division. The addition of a dedicated staffer brings the County more in line with MHSA regulations with the cost of 1 FTE at the program specialist level which is $100,006, plus benefits calculated at 50% for a total of $150,000. **(See Appendix A.)**

2. Previously Approved INN Programs and under Development for Future Procurement

A. Supportive Housing Land Alliance

Across the Bay Area, an inadequate supply of housing stock, particularly affordable housing, has contributed to rising home prices, rental rates, evictions, displacement and homelessness. Over the past five years, there have been significant declines in the number of licensed board and care facilities, residential hotels, and room and board facilities frequently utilized by individuals living on fixed incomes. Individuals with severe mental illness living on fixed Social Security disability incomes experience some of the greatest challenges in finding and maintaining housing in this region.

A Community Land Alliance (CLA), which will be based on a community land trust model, would be a nonprofit, community-based organization designed to ensure community stewardship of land. Community land trusts are often associated with conservation efforts, but there is also a significant effort to ensure affordable long-term housing through this form of ownership. The alliance will acquire land and maintain ownership of it permanently. The CLA enters into a long-term, renewable lease with residents. When the resident leaves, they earn a portion of the increased property value. The remainder is kept by the trust, preserving the affordability and purpose of the property for future households.

The proposed Innovation Project will promote interagency collaboration to create an **Alameda County Supportive Housing Land Alliance to develop and maintain supportive housing units.** ACBH will partner with Alameda County Housing and Community Development Department, housing and real estate legal and financial experts, consumer/client representatives, family member representatives, and existing nonprofit affordable housing developers to develop a land trust focused on supportive housing that incorporates unique aspects in order to address local conditions.

The Supportive Housing Land Alliance is a five (5) year project approved by the Mental Health Services Oversight and Accountability Commission (MHSOAC) August 22, 2019. Currently, it is in the procurement process.

3. INN Programs Currently in Progress

A. Community Assessment and Transport Team (CATT)

Alameda County's existing system for responding to behavioral health crises in the community is inefficient in terms of expense, time and connecting clients to appropriate services. A vast majority of

transports for individuals on a psychiatric hold are conducted by ambulance, which is expensive and requires law enforcement to wait for an ambulance to arrive. These calls are lower priority since they are generally not life-threatening, therefore increasing the wait time. In addition, the existing system transports an individual who qualifies for a 5150 involuntary hold, but those who do not qualify are left on site without a connection to services.

The proposed Innovation Project goal is to improve access to services in Alameda County by bringing together a few efforts to significantly transform the response to behavioral crises in the community:

- Develop a crisis response team that includes Behavioral Health Clinicians and an Emergency Medical Technicians (EMT) in order to provide both medical and behavioral assessments in the field, including in a medical emergency department. This team would initially be available 16 hours a day, 7 days a week, and focus on two communities that are identified as underserved. The team would be able to provide transport to the appropriate services, including psychiatric hospital, emergency department, crisis residential, sobering center or other site, for clients on 5150 holds or not requiring a hold.
- Enhance the bed availability software program (Reddinet) to show availability of psychiatric, crisis stabilization units, and sobering center beds and provide alerts when the psychiatric emergency services is reaching capacity in order to provide real time information about the availability of disposition options.
- Provide access to tele-psychiatry for the crisis response team in the field.
- Provide the crisis response team with access to a Community Health Record through AC Care Connect, which enables them to send an alert about the episode to other providers involved with the client.

By bringing together the right staffing and the right technology, this innovative crisis response team will *reduce unnecessary 5150 holds, transportation to medical facilities for medical clearance, and the many hours of waiting for clients and first responders.* In addition, it will increase access to appropriate services by connecting and transporting clients whether or not they are on a 5150 hold.

Progress Report

The CATT project currently is in the process of developing the project's infrastructure. An evaluator for the project has been procured and begun their supportive collaboration with the CATT project management team. Transportation vehicles for the crisis response teams are being procured. Training for the CATT teams has been set to begin in February, 2020.

As the CATT project infrastructure is being developed, a need for additional CATT team shifts has been identified to ensure coverage for the present needs of the County. Due to this new challenge, and delays in the development of the project's infrastructure, ACBH will be requesting not only more time, but additional funding for these teams. This request for more funding will include an extension, under the recently approved SB 79, for the project's AB 114 funding which are set to revert July 1, 2020.

SB 79 makes changes to existing law that would have reverted funds that counties received and not spent before July 1, 2017. SB 79 reallocates these funds to the county of origin for the purposes for which they were originally allocated. Currently, SB 79 is being interpreted to mean that counties can encumber funds without fear of reversion so long as the funds are expended before the end of the OAC approved project plan timeline, or three years for large counties/five years for small counties, whichever

is later. However, clarification of SB 79 is being sought because there are varying opinions of whether SB 79 extends to all fiscal years of AB 114 funds or only specific years. ACBH will continues with its request for an extension of its AB 114 funding until SB 79 has been clarified.

B. Transitional Age Youth Emotional Emancipation Circles

Emotional Emancipation Circles℠ (EEC) are support groups designed for African American people to "work together to overcome, heal from, and overturn the lies of White superiority and Black inferiority." This Innovation project will:

- Tailor the EEC model to specifically target the needs of African American young adults, while ensuring fidelity to the model, and
- Evaluate mental health and functional outcomes: The current EEC evaluation process focuses on participant satisfaction. By expanding the scope of the evaluation we can determine if young adults felt engaged and if it resulted in positive mental health and functional outcomes.

Progress Report

There have been significant delays in the County's procurement process. These delays have prompted the ACBH Child and Young Adult System of Care (CYASOC) to review the scope of work related to the project. Until procurement and contracting issues have been resolved, ACBH will not be able to implement the EEC programs as outlined in the original OAC approved proposal. Currently, it's unclear whether or not ACBH will be able to move forward with the program as planned within the timelines permitted with the Innovations grant. The County's procurement and contracting process may have to be redone. Timelines associated with any new procurement strategies are currently unknown.

Due to the many challenges of procuring and the contracting the EEC project, ACBH may be seeking an extension for the EEC project in early 2020.

C. Mental Health Technology Applications

Technology is on the forefront of innovation for health monitoring, be it physical or mental health. Alameda County is fortunate to be located on these front lines of technology. The County's unique location in the Bay Area provides residents close proximity to not only Silicon Valley, but numerous other technology companies, big, small, and emerging. This parity provides the County with a community that tends to embrace new technology with enthusiasm.

Mobile apps that focus on mental health can be used for a variety of purposes. They show great promise in promoting healthy behavior changes, increasing adherence to treatment programs, providing immediate psychological support, facilitating self-monitoring and reducing the demand for clinician time.[1] As mobile applications grow in popularity among the general public, so does the potential to increase the quality of care and access to evidence-based treatments through this technology.

Technology also brings with it a source of anonymity. Anyone with a smartphone is able to access technology, and in most instances, able to maintain their anonymity due to encryption methods. This can give the user a feeling of less loneliness, isolation, or the feeling of being judged; a sense of empowerment; and reduction in distress, anxiety or fatigue. These are all benefits of being in a support

[1] https://www.mayoclinic.org/healthy-lifestyle/stress-management/in-depth/support-groups/art-20044655

group according to the Mayo Clinic.[2]

This two and half years (2.5) project was approved by the MHSOAC on April 25, 2019 and intends to provide a platform for individuals who reside in isolation, anonymity, or feel they have no place to go because of their situation. This project offers new opportunities for outreach, and engagement, and support to these communities by testing a technology based delivery system for mental health solutions.

The project is currently in the procurement process.

4. INN Programs No Longer Under Development

A. Introducing Neuroplasticity to Mental Health Services for Children

This Innovation program was intended for the training and implementation of Holistic Approach to Neuro-Developmental Learning Efficiencies (HANDLE®) which is an approach to working with children and youth from a neuroplasticity perspective and paradigm. The HANDLE® approach was to be used with a selected group of school partners in Alameda County.

As a result of challenges with implementation timelines; inability to secure necessary procurements to provide training and certification for implementation partners; subsequent approvals required from participants were hindered or unsuccessful; and changes in leadership in ACBH's Child and Young Adult System of Care (CYASOC) directly affecting the project; the decision was made that CYASOC will no longer be moving forward with this particular MHSA Innovations program.

Future opportunities for the inclusion of the HANDLE® principles, practices, and /or future training opportunities are currently under advisement with ACBH's team.

B. Cannabis Education Program for Transition Age Youth (TAY) with Mental Health Challenges

This Innovation program was intended to address the changes in the laws regarding cannabis in California and provide an opportunity to find proactive ways to address the potential impact on mental health. Alameda County was proposing a collaborative approach to reducing potentially harmful effects on TAY mental health consumers. The focus of this proposed Innovation Plan was to collaborate with key stakeholders, including TAY consumers and the cannabis industry. Developing a positive and proactive collaboration with the cannabis industry is a unique approach to supporting the health of TAY

Due to modifications in the proposal design requiring further research and stakeholder input, ACBH's CYASOC will no longer be moving forward with this particular MHSA Innovations program.

Future opportunities for the inclusion of the Cannabis Education Program for Transition Age Youth with Mental Health Challenges are being investigated.

5. New INN Programs under Development for Future Procurement

Alameda County Behavioral Health (ACBH) is currently developing multiple proposals for the Innovations

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[2] Spurgeon JA, Wright JH. Computer-assisted cognitive-behavioral therapy. *Current Psychiatry Reports*, 2010; 12:547–552.

component of the Mental Health Services Act. Please note additional Innovations projects are being internally developed based on this summer's community input sessions and may be included when all Innovations projects are posted for the 30 day review period.

6. Innovation Grant Projects Completed

Round Four Innovation Grant Projects

Program Name:

INN 4B. Behavioral/Mental Health Career Pathways for High School and Undergraduate Students

Program Description: The MHSA INN Behavioral/Mental Health Career Pathways addressed challenges and barriers in building cohesive, effective academic and career pathway programs to attract, recruit, train and retain culturally, linguistically and economically diverse individuals into the public behavioral/mental health field. This project was intended to focus on students at the high school, community college and/or undergraduate level who had demonstrated interest in exploring behavioral/mental health careers.

This eighteen (18) month project has been completed. Refer to Workforce, Education, and Training (WET) section for details.

Workforce Education and Training (WET)

Alameda County Behavioral Health (ACBH), Workforce Education & Training (WET) uses multiple strategies to build and expand behavioral health workforce capacity including:

1. Workforce Staffing & Support
2. Staff Development, Training/Conferences and Consultants
3. Internship Program
3. Educational Pathways
4. ACBH Training Institute
5. Post Graduate Certificate Program
6. Psychiatry and Integrated Behavioral Health Care
7. Graduate intern Stipend Program
8. Loan Assumption program (not started/no data)
9. Consumer and Family Training, Education and Employment
10. MHSA Support and Community Based Learning (CBL) Training (new in WET section)

1. Workforce Staffing & Support

Program Description: Provides infrastructure to manage the development, implementation and evaluation of all Workforce Education and Training (WET) programs and initiatives. Spearheads partnerships with community-based organizations, peer-run agencies, educational institutions and local, regional and state agencies.
FY 18/19 Outcomes, Impact & Challenges: • In February 2019, the WET manager was invited to participate in the ongoing planning process for the 2020-2025 Mental Health Services Act Workforce Education and Training (MHSA WET), Statewide Plan facilitated by the Office of the Statewide Health Planning and Development (OSHPD). The WET manager has been participating in the ongoing discussion of the proposed program framework and the Regional Partnerships role to implement the 2020-2025 WET Plan supporting locally-defined workforce needs and interventions. • The WET manager provided oversight of the High School Career Pathways contract with FACES for the Future, eight Innovation and WET High School and Undergraduate Pathways contracts as well as the Bay Area Regional Workforce Partnership contract. • ACBH continues to serve as the fiscal sponsor for the Bay Area Regional Partnership program as outlined in the OSHPD Agreement Number 14-5004, which includes passing through the funds to California Institute for Behavioral Health Solutions (CIBHS). The WET manager continued to provide contract oversight. • The WET team administered and implemented the Graduate Intern Stipend Program, High School and Undergraduate Career Pathways activities and provided or collaborated on a total of 78 training activities, thereby training 2,614 staff and providing 381continuing education hours to ACBH and contracted provider staff. • ACBH WET and MHSA Innovation (INNWET) provided funding to eight grantees to implement mental/behavioral health career pathways pilot projects for eighteen months from October 2017

through March 2019. The total allocation for the project was $2,129,203. These pilot projects provided educational and training opportunities to underrepresented and disadvantaged high school and community college students to gain experience in the Public Mental/Behavioral Health.

- INNWET Learning Conference was held on February 15, 2019. All grantees had an opportunity to share their learning experiences, successes and challenges with stakeholders, institutions and policymakers. Short videos were produced to highlight the projects, speakers connected the grantees' work to broader strategies to develop the mental/behavioral health workforce in California, and presentations were given by each grantee group. Table displays were set up and project participants were able to speak to stakeholders about their personal experience in the programs.

- The WET team collaborated with various applicant organizations including the FACES for the Future and Diversity in Health Training Institute on their applications for State Grants as a collaborative partner.

- The WET Staff continued to provide administrative functions for Children and Youth Systems of Care (CYSOC), and Criminal Justice Mental Health Services/Conditional Release Program (CONREP) internships.

- The WET Training Officer served on the ACBH Training RFP Review Committee. Reviewed and scored grant applications.

- The WET team attended, presented and actively participated in the Bay Area WET Collaborative meetings and WET coordinator conference calls.

- The WET manager and staff continued to serve on various ACBH advisory committees, such as the ACBH Training Committee, Latinx Behavioral Health Workforce Action Group, Immigrant and Refugee Workforce Workgroup, WET Regional Partnership Steering Committee, Alignment Bay Area Health Pathways, East Bay Behavioral Health Workforce Workgroup, Alameda County Health Pathway Partnership (ACHPP) and the Berkeley City College Human Services Program Advisory Committee.

FY 19-20 Progress Report:

- ACBH is committed to continue WET activities and WET is currently funded through the MHSA Community Support Services (CSS) component. WET is focusing on workforce capacity building through behavioral health career pipeline development, training opportunities, and addressing strategies to recruit and retain hard to fill positions, increasing diversity, bridging gaps in skills set and improving language capacity.

- The WET team continues to prioritize, develop and implement projects based on the 2017 workforce needs assessment survey outcomes. They also continue to evaluate WET program impact and needs based on program outcomes and informational data.

2. Staff Development, Training/Conference and Consultants

Program Description: MHSA WET funds are used in a variety of ways to support staff development, provide additional trainings to targeted communities and utilize consultants to implement community or school based projects on a one time basis.

FY 19/20 Progress Report:

ACBH WET provided funding to the organization FACES for the Future (FACES) to provide follow up and continued engagement services to underrepresented students interested in pursuing a career in public mental and behavioral health. FACES has been working on the development and implementation of the following activities:

- FACES staff in collaboration with an ACBH WET undergraduate intern from California State University East Bay designed and distributed an alumni survey to the high school and undergraduate interns and event participants as an outreach effort. Results were limited and tended to be connected most to the Behavioral Health Undergraduate Summit and Bright Young Minds conference participants than the Life Academy program. Respondents reported needing continued assistance in navigating the pathway to behavioral health careers. In response, the FACES team designed a timeline of events and professional development opportunities to engage alumni. Currently phone outreach is set to begin late October, 2019 with offers of events in November, February and May as well as Mental Health First Aid certification for free during December and February for any alumni who are interested. Staff have also begun designing an alumni newsletter specifically for those alumni interested in mental and behavioral health that can be distributed quarterly and become another outreach tool to get alumni engaged in activities and data capture. One of the resounding messages during an alumni event held in August was that alumni need consistency in outreach, so all efforts are being made to ensure outreach is scheduled routinely and remains sustainable.

- FACES staff hosted graduation event for Life Academy seniors (OUSD School) in May, 2019. The event was attended by students, family and supporters. An alumna of the program, Nubia Flores Miranda, was honored with a scholarship from the Alameda Council of Community Mental Health Agencies in honor of Leslie Preston.

- FACES and the ACBH WET Manager have begun outreach to Merritt College and Laney College to support ongoing regional dialogue about pathway development as well as to offer trainings to develop skill sets in staff and faculty. Mental Health First Aid is one of those potential trainings and both sites are working to schedule trainings with faculty staff. FACES was able to meet with the Director of the CalWorks program at Laney College – this is a County subsidized work/school program for very high need students including those facing homelessness, newly arrived populations and system involved students. FACES is also presenting on the connection between community-based work and mental/behavioral health skills development at Berkeley Adult School for a class of Community Health Workers (CHW) in training. These are adults coming from multi-lingual, multi-cultural backgrounds who have an interest in CHW certification and continued skills development. The intention is to further engage this population in connecting to community based mental health pathway opportunities while building their understanding of how to work in community-based centers.

- FACES has provided Adult Mental Health First Aid certification trainings to Berkeley City College and Merritt College. In total, 54 participants were certified in MHFA.

In the summer of 2019:

- ACBH WET staff and FACES staff participated in the Oakland Unified School District (OUSD) Project Based Learning (PBL) Institute supporting teachers building pathways to health careers for Public Mental Behavioral Health (PMBH). In particular, Rusdale Continuation School was highlighted as a potential partner. Serving newcomer students who are academically at-risk, Rusdale is working to build out its pathway on-site as well as beginning to plan for work-based learning. This high need population would need direct intermediary assistance and supportive services in order to be successful.

- ACBH WET provided educational services to 37 high school and undergraduate students at Mentoring in Medicine and Science (MIMS).

3. Internship Program

Program Description: Coordinates academic internship programs across the ACBH workforce. Meets with educational institutions to publicize internship opportunities and provides training to Internship Programs.

FY 18-19 Outcomes/Impacts/Challenges:

The WET Team initiated a new planning process to develop more efficient onboarding process for Adult & Older Adult Systems of Care, Adult Forensic Behavioral Health and Vocational Rehabilitation Programs. Activities included:

- Consulting with program administrators to identify shared outcomes.

- Assessing individual program's needs, determining HR requirements and creating system processes to support flow, timely approvals and effective communication for internal stakeholders, end users and external institutions.

- Using the existing Intern Recruitment Timeline for structure.

- Developing efficient processes to streamline onboarding, thereby maximizing intern's experiential learning time, creating a single internal process (across the system of care) and positively impacting the workforce development pipeline.

Nine interns were placed with the Children's and Young Adults System of Care, nine with the Adult and Older Adult System of Care, six with the Conditional Release Program (CONREP) and five Pharmacy students with the Medical Director's Office.

- The creation of the Intern Recruitment Timeline and a process flowchart as well as ongoing relationship building efforts between the internship coordinator, HR, Finance and clinical teams has positively impacted efficiency and value add of the Internship Program. The competing priorities of multiple internal and external stakeholders requires a higher level of coordination and standardization.

Nine interns were exposed to a total of 25 trainings, including:

- Working with Schools and Special Education, CBT/DBT; Expressive Arts, Healthy Nutrition and Lifestyle; Working with Latino Immigrant Families; HANDLE (Holistic Approach to Neuro Development and Learning Efficiency); Career Advancement; Working with African American Families; Asian American and Immigrant Perspective on MH; Strive Program; Strengthening Relationships Through Partnerships; Documentation Training; Transformational Coaching; Objective Arts/CANS; Play Therapy; Pediatric Psychopharmacology; Suicide Assessment and Intervention; Bullying and Suicide; Early Childhood Assessment; Autism, and Eating Disorders.

- In-service training evaluations indicated a positive impact. Trainings and the trainers were extremely beneficial and well received by the interns.

Coordinated and facilitated annual internship fairs and internship orientations.

- Orientations at bay area colleges and universities give potential interns a first impression of ACBH in welcoming, low-pressure and informative settings. These are marketing *impact* activities, publicizing various learning opportunities and offering information and materials about ACBH's systems of care.

- Represented ACBH at 4 internship and health fairs at Cal State East Bay, UCSF, San Jose State and Holy Names College.

Challenges:

- Creating bandwidth/staff capacity for standardized intern processes across the Systems of Care pose challenges as individual staff will need to take on new functions to manage tasks, responsibilities and people within their programs to keep the new process functioning with integrity.

- While diversity is promoted as an essential priority there continues to be a challenging lack of Latino and especially African American male intern applicants.

- Recruitment challenges include identifying potential interns who speak ACBH's threshold languages and who reflect Alameda County's cultural diversity and committing adequate staff to cover two-day orientation events.

FY 19-20 Progress Report:

- Developing an improved system to collect and manage training and program evaluation results to inform program planning, intern recruitment, placement and follow up.
    - Introduced a new post-internship program evaluation for interns to complete. This effort seeks to gather information from the intern perspective for continuous improvement.
    - Continuing re-launch efforts, in conjunction with System of Care leaders, to create standardized guidelines, practice and protocol for onboarding interns in the Adult System of Care.

3. Educational Pathways

Program Description: Develops a mental health career pipeline strategy in community colleges, which serve as an academic entry point for consumers, family members, ethnically and culturally diverse students, and individuals interested in human services education, and can lead to employment in the ACBH workforce.

FY 18/19 Outcomes, Impact & Challenges:
 	
ACBH has developed and implemented the following activities:
 	
• **ACBH hosted nine high school students from June 18 through July 19 for 40 hours/week.** At ACBH, the students were paired with intern preceptors/mentors for 20 hours/week, and given project-based learning opportunities such as: learning to network, communicate and dress professionally, presentation skills, resume building, attending stakeholder and/or staff meetings, research and program evaluation, contracting procedures, and creating a resource guide for the Mental Health Service Act website. By doing work in an office setting, students gained valuable insight from an administrative perspective about key program development elements such as planning, coordination, team work and continuous quality improvement.
 	
• High School interns spent 20 hours/week in the classroom sessions to gain foundational learning about behavioral health concepts, and to explore and gain tools about their own health and wellness strategies. Classroom topics included: Mental Health 101, College prep and Career Pathways in mental health, recognizing and balancing life's stressors between school and home, participating in a healing circle, Trauma-Informed Care, and becoming a trained and certified Youth Mental Health First Aider.
 	
• **Bright Young Minds (BYM) conference** is a one-day, highly intensive day of structured activities for high schools that introduces students to careers in behavioral health. The WET Team, along with the organization called FACES and Oakland Unified School District planned, organized, and hosted the Bright Young Minds (BYM) conference on April 18, 2019 at the Cal State East Bay. It was a ground-breaking conference with 65 high school students from diverse and under-represented communities participating to explore behavioral health care career options.
 	
• WET is currently working in collaboration with the Ohlone College STEP Up Mental Health Program to support the development of the **Mental/Behavioral Student Advocacy Training Pilot Program**. Ohlone College will recruit a cohort of up to eight students from three key programs: Puente Program Learning Community, Umoja Scholars Program, and the Genders and Sexualities Alliance Student Club. Students will be trained using the "Wellness, Recovery and Resiliency" curriculum provided by ACBH WET. The program would include a service learning component where the students will plan and implement a service learning project that will help advance mental/behavioral health among their respective student group.
  o The WET manager is currently working in collaboration with the Ohlone College Student Health Director and the StepUp Mental Health Program Manager to possibly institutionalize the implementation of the "Wellness, Recovery and Resiliency" curriculum, developed by ACBH WET.
  o The StepUp Mental Health Program is exploring the curriculum approval process with the College Curriculum Committee Chair in response to the WET manager proposing the institutionalizing of the Wellness, Recovery and Resiliency curriculum.

  - The WET team is revising the existing mental/behavioral, 12-module curriculum, "An Introduction to Behavioral Health Care Services: Curriculum on Wellness, Recovery and Resiliency" through a contract with California Association of Social Rehabilitation Agencies (CASRA).

- The WET manager assisted Ohlone College to cultivate partnerships with ACBH systems of care leadership as the College applied for a state grant. One of the funding activities was to develop stronger relationships with the county behavioral health and the community based mental health services. WET manager also collaborated with the College in their application for the Peer Personnel Training and Placement through OSHPD.

- The WET team is exploring ideas and strategies regarding setting up **a non-licensed/license-eligible clinical supervision pilot project** to help eligible clinicians gain their supervision hours. The goal of this project is to increase the number of licensed bilingual and clinicians of color to fill hard-to-fill/retain positions in the County and CBO programs. In 2017, WET conducted a needs assessment survey and organizations reported an increasing demand and shortage of licensed clinicians, especially LCSWs. WET team is working with the ACBH systems of care leaders to identify needs for each system as well as seeking input on program design, including supervision methods to build a pipeline that can potentially address the licensed-staff shortage issue.

ACBH WET team is currently engaged in, or completed:

- Discussing with the Department of Health Sciences Undergraduate program at California State University East Bay, to participate in the Undergraduate Capstone Internship Project. The focus of the Capstone Project is Problem-based Learning (PBL). Students learn about a subject by working in groups to solve an open-ended problem. Instead of learning concepts and topics and then applying them to a situation, PBL courses begin with a problem statement of practical importance. In groups, students explore what they know about the issue, determine what information is still needed, and identify where relevant topics, data, and tools can found to solve the problem. ACBH WET team will provide four problem statements for the PBL projects and from early January, 2020 will start working with a cohort of twenty-four students, which is sub divided into four teams of six students.

- ACBH WET as a Bay Area Mental Health and Education Workforce Collaborative partner, coordinated, and co-hosted Adult and Youth Mental Health First Aid Instructors trainings to thirty-four people.

- ACBH WET is currently coordinating and scheduling presentations on Mental Health 101, Mindfulness, Depression and Suicide as requested by local high school teachers.

- ACBH WET funded Wellness in Action (WiA), a workforce development program, at the Center for Empowering Refugees and Immigrants (CERI). WiA works with *community leaders* from indigenous, refugee, and immigrant communities interested in promoting mental health and wellness. WiA will offer five mini-grant awards to support grassroots community leaders and provide technical and clinical consultation and skill building trainings for careers in community mental health.

D. WORKFORCE EDUCATION & TRAINING (WET) PROGRAM SUMMARIES

WET INN 4B Project: Behavioral/Mental Health Career Pathways for High School & Undergraduate Students FY 18/19 Final Report Outcomes:

ACBH WET and INNOVATIONS (INN) provided funding to eight grantees to implement mental/behavioral health career pathways pilot projects for eighteen months from October 2017 through March 2019. The total allocation for the project was $2,129,203. These pilot projects were funded by MHSA INN to provide educational and training opportunities to underrepresented and disadvantaged high school and community college students to gain experience in the Public Mental/Behavioral Health. MHSA INN funding intended to provide the mental health system with an opportunity to learn from innovative approaches.

During the 18 month project, grantees were required to meet collaboratively on a quarterly basis where they provided updates on project progress to their colleagues, collectively addressed questions related to projects and shared lessons learned as a group to hone best practices. The quarterly meetings also allowed ACBH to address any questions related to contracts, financial reporting, reporting requirements and other key deliverables for the contract period.

- High Need Student Populations: All INN4 grantees worked with high need student populations without exception. Students in the project came from trauma backgrounds, where food and housing is insecure, care management is needed, and required safety net services to participate in projects. Oftentimes, students needed to have those basic needs met before the work of career exposure could begin. This was true regardless of age; with adults living in low socio-economic situations needing as much support as youth. As a result of this grant cycle, ACBH has a deepened appreciation for the safety net services required when targeting underrepresented student populations for workforce development and pipeline programming into Psychiatric and Behavioral Mental Health (PBMH) careers.

- Diversity in the Workforce: When properly supported, diverse students can increase their interest in professions in PBMH. The student cohorts that were served were racially, ethnically and linguistically diverse with students reporting lived experience and low socio-economic status. Examples of student populations served are newcomer and refugee populations; formerly incarcerated youth; parenting students; and those who were working toward a high school diploma. The safety net services needs to be present in pipeline programming, with support in place for a wide range of young people to become interested in pursuing a career in PBMH.

- Mentorship is Key: Across the board, successful INN4 programs were projects in which mentorship was well-established and students had a caring professional to go to for support. This was not always directly related to financial need, but also related to healing, particularly for those students struggling with trauma backgrounds, community violence or refugee status. Projects utilized mentors in a variety of ways including professional panels, internship supervisors and of course, project staff. A collective network of caring adults surrounding a student with encouragement was fundamental to seeing increases in interest in pursuing a career in PBMH.

- Employer Preparedness: All grantees reported difficulty interacting with mental and behavioral health providers in trying to support students interested in the field. A lack of diversity among professionals, a lack of understanding of how to work with students, and a lack of institutional supportive structure that allowed for work-based learning were significant barriers to the INN4 projects.

- Stigma Reduction: When students are exposed to and supported through an introduction to mental health topics and professions, stigma about accessing services, stigma about others accessing services, and reluctance to pursue a career in PBMH are reduced. This outcome is particularly encouraging as it shows there is a direct correlation between exposure and reduction of stigma for accessing services as well as career goals, which are both main areas of focus for MHSA.

The MHSA INN4 WET projects were universally successful in targeting multi-lingual, multi-cultural student populations who are historically left of out of the PMBH workforce. This is a critical requirement of the MHSA workforce development strategy to increase access to PMBH services for diverse and underserved communities in California. All INN4 projects were successful in meeting contract deliverables, staying fiscally and administratively compliant and with ensuring that students received thoughtful and well-designed programming. All INN4 projects were welcomed by the community during the INN4 Learning Community Conference and all projects successfully worked to reduce stigma in their student cohorts both in terms of accessing mental health services, as well as mental health careers.

As stated earlier, ACBH has a deepened appreciation for the types of safety net services required by this student population. Living in the Bay Area, facing economic and environmental stresses, managing trauma backgrounds; all required that supportive services be embedded in programs working on PMBH career exposure. This was universally true for both youth and adult populations. Moreover, actively working to reduce stigma supports a young person's interest in pursuing a career in PMBH. Workforce development programming operating at the high school and college level must include stigma reduction and supportive services to be successful. In addition, mental health employers interested in providing work-based learning for interested students, must be properly trained and on-boarding processes need to be streamlined in order to manage this population. Having mental health providers involved in workforce development efforts is key for ensuring that the process of interacting with mental health service organizations does not negatively impact a student's interest in the career path.

Grantees were coached on sustainability strategies for their work. This coaching enabled several grantees to find other funding mechanisms to sustain their program. Several of the grantees continue to be in the process of seeking funding or have placed the project on hiatus until an alternative funding source can be secured.

FY 20/21 Anticipated Changes:

- ACBH WET does not anticipate any significant program implementation changes during FY 20-21.

4. ACBH Training Institute

Program Description: Provides a coordinated, consistent approach to training and staff development. Develops, researches and provides a broad array of training related to mental health practice; wellness, recovery and resiliency; peer employment and supports and management development.

FY 18/19 Outcomes, Impact & Challenges:

- Provided or collaborated on a total of 78 training activities, thereby training 2,614 staff and providing 381 continuing education hours to ACBH and contracted provider staff.

- Training topics covered a variety of issues including, Culturally Responsive Mental Health Services for Sexual Orientation and Gender Identity (SOGI), Tobacco Cessation Interventions, Adult and Youth Suicide Assessment & Intervention, Coaching for Collaboration, Commercially Sexually Exploited & Trafficked Youth, Developing Culture-Based Wraparound for African American Transitional-Aged Youth, Navigating Systems for Adolescents with Autism Spectrum Disorder, Best Practices and Inspiration for Senior Injury Prevention Advocates, Preventing, De-Escalating, and Managing Aggressive Behavior in Behavioral Health Settings, legal and ethical issues, and a variety of Evidence-Based Practices.

- Provided trauma informed care related trainings including Becoming a Trauma Sensitive Workforce, Transforming Trauma - How to do this Work and Sustain, Preventing Vicarious Trauma, and Trauma-Informed Treatment for Adults, Children, & Teens.

- In collaboration with the Office of the Medical Director, a one-day Educational Summit on Cannabis was held for all health care services clinical staff including psychiatrists, physicians, and nurses.

- A full day training was provided in Farsi for County and community-based organization (CBO) staff called "Concepts of DBT and CBT as Applied to Collectivistic Culture of Farsi Speaking Populations."

- Training outcomes are measured using self-administered evaluations. Each training proposes measurable learning objectives to be achieved by the end of the training. Following the training, attendees evaluate whether the objectives are met using a Likert scale from 1-5 (strongly disagree to strongly agree). At the end of every training, participants are asked to complete an evaluation and if they want continuing education credit, it is required. For all trainings, learning objectives are evaluated as being met on average as at least a 4 or 5 of the Likert scale, with 5 being "strongly agree."

- Another type of evaluation being utilized is a Post-Test, which training participants can take to test their knowledge during the training. The training instructor reviews the test with participants in order to get a sense of their learning and to address any incorrect answers and questions that may arise from taking the Post-Test.

- Another outcome measure was utilized for the trainings on Becoming a Trauma Sensitive Workforce. Two-weeks following the trainings, a post-training survey was emailed to all participants. It contained three simple questions about the impact of training and whether changes in perspective or behavior occurred/persisted as a result of the training. The survey results averaged over a three-year period indicated that between 62% of respondents (182) were positively impacted by the training and 72% made a change because of the training.

Challenges:

- Evaluating the impact of trainings is a challenge for any type of training in all sectors and as a way to address this, the Workforce, Education, & Training unit began scheduling presentations on related topics at the monthly Training Committee meetings. In February, Deanna Beeson, Director of Clinical Learning at Telecare, Inc., gave a presentation entitled, "Methods of Supporting Training Sustainability & Measuring Outcomes" and in October, Stella Sheldon, Training Manager from A Better Way, will present on Learner Retention Strategies.

- Because a number of units within ACBH host trainings for their staff and contracted providers, it has been a challenge to coordinate all that is necessary in order to provide continuing education credits for the numerous trainings being offered. Starting in July, WET formalized collaboration with other programs within ACBH who want CE credit for their trainings. The result of the collaboration has been more consistency and standardization for training participants. The established collaborations include the Office of the Medical Director, Office of Ethnic Services, Substance Use Disorders System of Care (SOC), the Child & Young Adult SOC, the Adult & Older Adult SOC, and Quality Assurance.

- All of the trainings provided have been in-person at various locations throughout the county. It is challenging for a number of staff to attend trainings due to the added travel time needed. For this reason, among others, we are considering providing on-line trainings once the new learning management system is in place. *(To view the Training Institute's report in detail, see Appendix B.)*

FY 19/20 Progress Report:

- Provided or collaborated on a total of 96 training activities, thereby training 2,842 staff and providing 422.5 continuing education hours to Behavioral Health Care Services (ACBH) and contracted Community Based Organization's (CBO) staff. See the addendum for a list of trainings provided.

- Training topics were provided on a variety of issues including legal and ethical issues, Culturally Responsive Mental Health Services for Sexual Orientation and Gender Identity (SOGI), Tobacco Cessation Interventions, Adult and Youth Suicide Assessment & Intervention, Mental Health First Aid, Preventing, De-Escalating, and Managing Aggressive Behavior in Behavioral Health Settings, and a variety of evidence-based practices.

- Seventeen of the trainings were hosted by the Office of Ethnic Services and related to one or more of the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS). Trainings included a five-part intensive workshop series called "Caught in the Crossfire of Cultures", which focused on the psychological problems of the Afghan population residing in Alameda County; "Strong, Brown & Proud-Genesis of the Latina/o x Raza: The State of Latina/o x Raza in CA Today"; "Treatment & Beyond: Improving Retention and Treatment Outcomes for African Americans through Effective Case Management, Dismantling Implicit Bias, and Healing Racial Trauma"; "From Color-Blindness to Cultural Humility and Cultural Competence: Understanding Whiteness and Its Implications for Health Equity Training"; and "Behavioral Health Interpreter Training."

- Provided continuing education credit for workshops at the 2-day Asian & Pacific Islander (API) Mental Health Empowerment Conference "Unified in Resilience, Drawing Strength from our Communities", a statewide conference with 500 in attendance on the first day and 350 on the second day.

- Provided trauma informed care related trainings to County and CBO staff, including "Preventing Vicarious Trauma", "Dynamic Mindfulness", and "Trauma-Informed Treatment for Adults, Children, & Teens."

- A training "Traumatic Impact of Immigration on Children and Families" was provided in Spanish. We are planning to offer at least two more trainings in Spanish by the end of June 2020.

- Continue to maintain provider accreditation and offer required continuing education (CE) credit for Registered Nurses, Licensed Marriage and Family Therapists, Licensed Clinical Social Workers, Licensed Professional Clinical Counselors, Licensed Educational Psychologists, Licensed Clinical Psychologists, and certified Addiction Professionals.

- Continue to provide trainings in both Adult and Youth Mental Health First Aid for staff and the community.

- Through a collaboration with California State University East Bay, WET is providing the continuing education credit for their two-year post graduate Infant and Early Childhood Mental Health certificate program. Students began course work in January.

- In March 2019, ACBH contracted with East Bay Agency for Children (EBAC) to provide Trauma Informed Systems (TIS) 101 training to help participants understand how trauma and stress impact developing bodies and brains, communities, organization, and systems. EBAC will provide a train-the-trainer model on the topic of TIS for a cohort of trainers. In August, a cohort of 10 trainers began the certification process and will deliver TIS trainings to County and CBO staff beginning in October. The plan is for the trainer cohort to provide an average of two TIS trainings a month from October 2019 through June 2020.

- In June 2019, through a collaboration with the California Institute for Behavioral Health Solutions (CIBHS) and funding provided by the Greater Bay Area Mental Health and Education Workforce Collaborative, WET co-hosted a week-long course for an Adult Mental Health First Aid (MHFA) instructor certification. Nine persons became certified as instructors representing both ACBH and community-based organizations.

- The Training Committee continues to meet monthly (8 times per year). The committee is composed of representative staff and managers from county units and CBOs. The Training Committee advises the Training Officer on training activities related to both clinical and administrative staff throughout our system. In addition to the presentations and group discussion related to training outcomes and sustained learning that was discussed in the previous section, the training committee has reviewed standards of practice for trainings such as "person- first" language, fostering an inclusive environment, creating trauma informed learning environments, and using strengths-based and non-stigmatizing language. In June, Nicole Nelson, Executive Director of Training at Seneca Family of Agencies, presented to the committee on "Setting Expectations for Trainers around Equity and Inclusion" and how participants might apply these ideas to their own settings.

FY 20/21 Anticipated Changes:

- In February 2019, the Alameda County Learning & Education Center received official Board approval for the purchase of a new Learning Management System. *SumTotal Systems* will be the new LMS vendor, and WET is a member of the implementation team and the representative of our department in the process. *SumTotal* will provide a data management system for self-registration and tracking of instructor-led training, online, informal, and social learning, which supports career growth and development. This new LMS includes significant additional features, improved options for managers, and has a more advanced user experience. It will continue to offer the ability for all County employees and CBO staff to register for ACBH trainings. During the remainder of 2019, WET is involved in the configuration and implementation phase with a plan to "go-live" with the new system in January 2020.

- As mentioned in the previous section, the trainings provided to date have all been in-person, which presents a challenge for a number of staff due to the added travel time needed. The new LMS system provides a platform allowing the ability to launch and learn on mobile devices anytime, anywhere. We are excited about the opportunity to utilize this function to be able to provide online learning content including, but not limited to, courses, videos, books, etc.

5. Post Graduate Certificate Program

Program Description: MHSA WET provided funding to launch a new two-year *Infant & Early Childhood Mental Health Postgraduate Certificate Program* at Cal State University, East Bay. The overarching goal is to build capacity in a culturally diverse early childhood mental health workforce to meet the social, emotional and developmental needs of young children, ages birth to five, and families in Alameda County.

- The first year of this program has focused on the developmental foundations of infant and early childhood mental health with an emphasis on theory. Year Two is developmental foundations of relationship based clinical work with infants, young children, families and caregivers with an emphasis on application of theory to every day practice. The curriculum has a strong emphasis on working with families from diverse cultural, racial and ethnic backgrounds. This is especially important as Alameda County is exceptionally diverse in terms of socio-economic status, race, culture, ethnicity and immigration experiences.

- The program began last year and is continuing with a cohort of 15 students, 14 subsidized by MHSA WET and one private pay. Of the 15 students 11 are clinicians of color and 10 of the 15 speak a second threshold language, and all 15 are working in Alameda County early childhood community based organizations (CBOs).

Program Evaluation:
The Cal State University East Bay Infant & Early Childhood Mental Health Postgraduate Certificate Program is being evaluated by UCSF Benioff Children's Hospital Oakland, Dr. Laura Frame, Director of Research, over the two-year period of implementation. The two-year evaluation will focus on evaluation of the process and methods used in the training program. To this end, the evaluation will provide ongoing feedback to program planners and teaching staff that will support continuous quality improvement during the two-year program, as well as post-pilot.

Challenges:
The following are challenges that the program planner and teaching team experienced in the initial phase of launching the program:

- Amount of time that was required to develop the curriculum was considerably more than had been projected. This required additional compensation for the teaching team.
- Variance of student experience and knowledge – teaching team had to revise some of the curriculum to reflect the variance of experience and knowledge of the student cohort.
- Variance of teaching team (one primary instructor and two co-instructors) experience – Primary instructor realized early on in the process that one co-instructor was considerably more prepared to develop and present curriculum. This required extra planning among the team in terms of delegation of curriculum development and instructional responsibilities, as well as differential compensation for one co-instructor.
- Although Cal State East Bay Continuing Ed staff are exceptionally collaborative and helpful, there was a learning curve on use of educational platform for teaching team.

Students received “past due tuition” notices from Cal Sate East Bay throughout the first semester although all tuition had been subsidized and completely paid for. This situation has been resolved and should not occur moving forward.

6. Psychiatry and Integrated Behavioral Health Care

Program Description: MHSA WET provided funding to continue its partnerships with nine Federally Qualified Health Centers (FQHCs) and the University of California, San Francisco (UCSF), School of Medicine to provide behavioral health education and clinical training.

- The Office of the ACBH Medical Director funded the fifth cohort of nine FQHC primary care providers to attend the University of California Davis, School of Psychiatry, and Primary Care Psychiatry Fellowship Program. This year the ACBH Workforce Development Project includes two Safety Net primary care providers who will be attending the new UC Davis School of Psychiatry Pain Management Fellowship Program, which aims to increase the skills and knowledge base of providers to respond to the needs of patients with opioid addictions.

- ACBH WET and the University of California, San Francisco (UCSF), School of Medicine partners to provide behavioral health education and clinical training to Fellows from UCSF Public Psychiatry Fellowship (PPF) Program. However, in FY 2019-20, UCSF was unable to recruit anyone to place in the ACBH clinical education and training program.

7. Graduate Intern Stipend Program

Program Description: Offer financial incentives as workforce recruitment and retention strategies, and to increase workforce diversity. Financial Incentives are offered to individuals employed in ACACBH and to graduate interns placed in ACACBH and contracted community-based organizations, and who are linguistically and or culturally able to serve the underserved and unserved populations of the County.

FY 18/19 Outcomes, Impact & Challenges:

- WET continued to provide Financial Incentives to eligible graduate interns placed in ACBH and contracted community-based organizations, and who are linguistically and culturally able to serve the underserved and unserved populations of the County.

Launched and administered the 7th cycle of the Graduate Intern Stipend Program in August 2018.

- Awarded 20 stipends in the amount of $6,000 each for 720 internship hours. Of the 20 awardees, 70% represent the diverse communities of Alameda County.

2018-19 Graduate Intern Stipend Awardees – Ethnicity (Number of awardees =20)

African American	4 – 20%
Asian Pacific Islanders	3 – 15%
Caucasian	2 – 10%
Hispanic/Latino	7 – 35%
South East Asian	4 – 20%

2018-19 Graduate Intern Stipend Awardees – Language (Number of applicants=20)

English	4 – 20%
Cantonese	1 – 5%
Mandarin	0
Spanish	9 – 45%
Tagalog	0
Vietnamese	2 – 10%
Other	4 – 20%

Challenges:

- With eight years' experience gained from participating in the State-funded Mental Health Loan Assumption Program (MHLAP), ACBH WET invested enormous amount of time relentlessly working with two experienced and well-known entities to develop a contract to implement a local loan repayment program, the "Alameda County Loan Repayment Program". Due to technical issues and the inability to meet County contract requirements between ACBH and the contracted party, WET was unable to move forward with the contract.

FY 20/21 Anticipated Changes:

- ACBH WET does not anticipate any significant program implementation changes during FY 20-21.

8. Loan Assumption Program

Program Description: Mental Health Loan Assumption program for individuals who complete a service obligation in public behavioral health in Alameda County.

In FY17-18, Office of Statewide Health Planning and Development (OSHPD) funding supporting the State Mental Health Loan Assumption Program (MHLAP) ended. This created a service gap in providing financial incentive to hire and retain qualified, eligible employees in "hard to fill/retain" positions in Alameda County's Behavioral Health Care System. ACBH WET took necessary actions to bridge the gap, focusing on developing a local Loan repayment program, the "Alameda County Loan Repayment Program" (ACLRP), modeled after MHLAP. The WET manager continued to work and negotiate with two experienced and well-known entities to develop a contract for a local loan repayment program – ACLRP, however as to date, the program has not been developed due to implementation challenges. The WET manager is continuing to seek additional partners to implement this project.

9. Consumer & Family Member Training, Education and Employment

Program Description: Offers an integrated, coordinated approach to consumer and family member employment and supports consumer and family employees at all stages of the employment process, from recruitment to retention. The goal is to develop and retain authentic consumer and family member voices in leadership roles as we develop new wellness, recovery and resiliency practices across the system.

FY 18/19 Outcomes, Impact & Challenges:

- BEST Now, a program with Alameda County Network of Mental Health Clients (ACNMHC), provides peer specialist training program with 6-month internships: 19 students attended the program and graduated in June 2019. This year the training added Substance Use prevention and harm reduction courses.
- The Office of Consumer Empowerment (OCE) offered a Crisis and Peer Support Training in April 2019. 17 peer specialists completed the training.
- Pool of Consumer Champions (POCC) Latino Committee hosted and provided a Latino Empowerment Training and Event in September. 135 consumers, family members and providers attended the training.
- POCC partnered with California Association of Mental Health Peer Run Organizations (CAMHPRO) to leverage state funding to bring more trainings and employment opportunities to consumers. The POCC hired 11 peer staff from the training cohort.
- 23 on-going trainings for consumers were provided for Lift Every Voice and Speak Speakers Bureau in FY 18/19. They were trained in Toast Masters curriculum. 24 consumers were trained who are part of the Speakers Bureau.
- POCC Sexuality and Gender Alliance Committee (SAGA) presented the Supporting the Wellness of Transgender Communities Training to 30 consumers, family members and providers.

- e-CPR (Emotional CPR) train the trainer was offered in March 2019. 12 participants completed and received certificates.
- Advanced Peer Specialist trainings/educational experiences were offered to build knowledge, skills and abilities which included DBT 32-hour online training. However, DBT 32-hour online training series ended in September 2019. Many participants have experienced challenges due to technical glitches as the software is outdated and expiring.
- The Office of Family Empowerment (OFE) provided 2-day coaching skills training to support Family Partners and their Supervisors to increase communication, collaboration, connection and humility in service delivery to families and in the workplace.
- OFE implemented 18 hours of on- site technical assistance and coaching to Family Partners and Supervisors in three early childhood mental health agencies to practice and integrate coaching skills introduced at the two-day coaching training. The training and technical assistance resulted in a greater awareness and self-management of triggers especially related to trauma and high stress situations, a shift from solving problems to supporting family strengths and internal resources, and increased collaboration, communication and connection between Family Partners and their Supervisors.

10. MHSA Support and Community Based Learning (CBL) Trainings

Program Description: Community Based Learning (CBL) Trainings are free to Alameda County Behavioral Health Care Services (ACBH) systems partners, faith based communities and non-profit organizations that want to improve health outcomes for consumers and family members in the areas of mental health and substance use disorders.

Alameda County Behavioral Health Care Services Ethnic Services Department is able to offer trainings through funding from Prop 63, the Mental Health Services Act (MHSA). For more information on these trainings please go to: https://acmhsa.org/innovation-community-based-learning/community-based-learning-trainings/

Capital Facilities & Technological Needs (CFTN)

The Capital Facilities & Technological Needs (CFTN) component of the MHSA "works towards the creation of a facility that is used for the delivery of MHSA services to mental health clients and their families or for administrative offices. Funds may also be used to support an increase in peer-support and consumer-run facilities, development of community-based settings, and the development of a technological infrastructure for the mental health system to facilitate the highest quality and cost-effective services and supports for clients and their families".

It should be noted that CFTN funding was originally a 10 year block grant, which ended on June 30, 2017. However, through Assembly Bill (AB) AB 114, ACBH was given a grace period to utilize previously reverted MHSA funding through June 30, 2020. For more information on ACBH's spending plan for AB 114 funds, please see ACBH's AB 114 Plan at https://acmhsa.org/reports-data/#mhsa-plans

In addition to the CFTN funds identified in Alameda's AB 114 Plan, ACBH began transferring CSS funds to CFTN in FY 18/19 and again in FY 19/20. Pursuant to Welfare and Institutions Code Section 5892(b), Counties may use a portion of their CSS funds for WET, CFTN, and the Local Prudent Reserve. The total amount of CSS funding used for this purpose shall not exceed 20% of the total average amount of funds allocated to that County for the previous five years.

NEW Capital Facilities & Technology (CFTN) Projects

Through our Community Input process in FY 17/18 the areas of housing, homelessness and the availability of crisis services (to reduce/prevent hospitalizations) were top concerns reported by local residents. BHCS is aligned with these issues and is developing a multi-prong approach to improve crisis access as well as partner with the community to reduce homelessness for individuals with severe mental illness. It should also be noted that ACBH's MHSA funded Capital Facilities projects are in alignment with Alameda County's Vision 2026. More on this vision can be seen at https://vision2026.acgov.org/index.page

During FY 19/20 the following CFTN projects were implemented. These projects were listed in the FY 18/19 Plan Update as new programs, but have now moved to the ongoing section of this Update. Several of these projects will be completed this fiscal year and others will be continued and completed in FY 20/21.

E. CAPITAL FACILITIES & TECHNOLOGY (CFTN) PROGRAM SUMMARIES

Ongoing CFTN Projects

Project Name: Land Purchase adjacent to the A Street Homeless Shelter

Project Description: In FY 18/19 ACBH used its AB 114 CFTN funds to purchase a small plot of land next to the A Street Homeless Shelter, which ACBH has been operating in Hayward since 1988. The subject lot is located at 22385 Sonoma Street immediately adjacent to the existing A Street Shelter.

FY 19/20 progress: ACBH, through the General Services Agency (GSA), successfully purchased the land in January 2019. ACBH plans to use the lot as additional parking, providing approximately 20 additional spaces to augment the inadequate parking capacity needed to serve employees, residents, visitors and service vehicles. The grading and fencing of the space will take place once the contaminated soil is removed; which should be completed by January 2020. GSA is currently overseeing the project for ACBH. In the future this land may be augmented to expand the A Street Shelter capacity.

Project Name: Alameda Point Collaborative

Project Description: Starting in FY 18/19 ACBH utilized AB 114 CFTN funds to invest in the Alameda Point Collaborative (APC) Senior Housing and Medical Respite Center (Center) to help alleviate the homelessness crisis and address adverse health outcomes among vulnerable populations in Alameda County. This project's focus is to develop permanent supportive housing, medical respite and extended care to people experiencing homelessness, with an emphasis on medically frail and individuals with complex medical and psychiatric needs. See the FY 18/19 MHSA Plan Update for a more detailed project description at www.ACMHSA.org

FY 19/20 Progress: The City of Alameda held a special election in April 2019 to determine if the project could move forward. The ballot measure passed with 53% of the voters approving to move forward with the development of the Center. Once the special election was finalized ACBH released its first payment to APC to invest in the building and renovation development. ACBH will report out additional progress as dates become available.

Project Name: Investment in facility development for the Berkeley Wellness Center

Project Description: ACBH and the City of Berkeley have partnered to develop a Wellness Center for the City of Berkeley in order to serve north county residents who have a mental health diagnosis or have experienced mental health challenges who will benefit from a cohesive set of wellness and recovery services. ACBH dedicated AB 114 CFTN funds to develop this facility.

FY 19/20 Progress: The Berkeley Wellness Center, is now open and operated by Bonita House.
The program opened on November 4th, 2019 and is jointly funded by ACBH and the City of

Berkeley using MHSA CSS funds. This program will be listed in future MHSA Plans as OESD # 18.

Project Name: Investment in the final construction stages of the new dual crisis stabilization unit (CSU) and crisis residential treatment (CRT) program located in North Oakland called Amber House.

Project Description: ACBH was awarded grant funds under SB82 (Investment in Mental Health Wellness Act of 2013) to develop a 14-bed crisis residential treatment program operating in tandem with a 12-bed crisis stabilization program. MHSA funds were used to leverage the final construction costs.

FY 19/20 Progress: On September 17, 2019 Amber House was opened.

Amber House CSU is a 12-bed voluntary-only CSU, whose purpose is to assess individuals who are having a mental health crisis and are in need of assessment, stabilization, and brief treatment. The service is available to individuals for up to 24-hours.

Amber House CRT has up to 14-beds for individuals in crisis who do not meet medical necessity criteria for hospitalization and would benefit from treatment and supportive programming. Amber House, as well as ACBH's other crisis residential services, are available to only clients who are residents of Alameda County who possess and/or eligible for Medi-Cal.

It's anticipated that the development of this CSU/CRT program will significantly reduce overcrowding at John George and reduce the impact on the emergency department of local hospitals while providing more accessible services to the residents of Alameda County. This increase supports ACBH's ultimate goal of expanding the County's number of beds at facilities throughout Alameda County. Operating costs for Amber House will be covered by Medi-cal reimbursement and MHSA CSS funding. This program will be listed in future MHSA Plans as OESD # 11.

Project Name: South County Homeless Project (SCHP)

Project Description: The South County Homeless Project (SCHP) emergency shelter provides 24 shelter beds for men and women with serious mental illness currently experiencing homelessness. The shelter operates out of a county-owned property located at 259 A Street in Hayward and has not received any significant maintenance or upgrade work since it was first used for this purpose in 1989.

FY 19/20 Progress: At the request of ACBH with MHSA financing, the Alameda County General Services Agency (GSA) completed an assessment of the property and identified some key areas in need of repairs including the Heating, Ventilation, and Air Conditioning (HVAC) systems, electrical, plumbing, fire safety and prevention systems, and other areas identified in their report. The proposed repairs are in process and expect to be completed by the end of calendar year 2019.

E. CAPITAL FACILITIES & TECHNOLOGY (CFTN) PROGRAM SUMMARIES

Program Name: MHSA Technology Project

Program Description: Purchase, installation and maintenance of a new Behavioral Health Management Information System, to include: billing, managed care, e-prescribing functions, data interoperability and functions as needed to support clinical and fiscal operations of BHCS. Additional expenditures for the necessary support staff during the implementation process, and other projects that provide access to consumers and family members to their personal health information and other wellness and recovery supports.

FY 19/20 Progress: ACBH has utilized CFTN funds to contract with an agency, XPIO, to develop a scope of services and requirements for the procurement process for a new EHR system. This system will include: billing, managed care, e-prescribing functions, data interoperability and functions as needed to support clinical and fiscal operations of ACBH.

It's the goal to have an RFP released by January 2020 and a contract in place by the end of FY 19/20 for work to begin in FY 20/21. More information will be shared with the community when available.

Additionally, under this project ACBH has been utilizing CFTN funds for the following items that have assisted ACBH in being more efficient and effective with utilization and outcome data:

- Behavioral Health Management Contracting System (to assist with the contracting process), called Apttus (phases 1-4)
- Web-based dashboard System, called YellowFin
- Computer/Technology Technical Assistance
- Electronic File Storage and Document Imaging (Veeam Software)
- Clinician's Gateway Interface
- County Equipment and Software Update (includes GoToMeeting software)
- CFTN Administration

Alameda County Behavioral Health appreciates your time and interest in reading this Plan Update. We look forward to engaging with you and all of our communities in the upcoming Community Planning Process this spring. Please look for updates on this timeline on our MHSA website at www.acMHSA.org

APPENDIX A.

Funding for Community Planning Process and Stakeholder Input for Increased Innovation Planning, Design and Implementation

Introduction

Alameda County Behavioral Health (ACBH) continues to be fully invested in having a dynamic and robust Community Planning Process (CPP). The community involvement from the residents of Alameda County is *essential to Innovation (INN) planning and program development*. Alameda County began a comprehensive CPP that spanned several years after Prop 63, Mental Health Services Act (MHSA), was passed by voters in 2004. Alameda has continued to conduct CPPs, however, as a large and diverse county, Alameda has had challenges in its outreach to many of its diverse populations. These challenges include outreach and engagement to the unserved and the underserved individuals in both urban and rural areas. The County is dedicated to developing a revitalized and improved approach to ensure more meaningful input from all **individuals living in the county.**

What Has Been Done

ACBH has engaged in CPPs for years to ensure the County's diverse communities' needs are provided for and addressed in the Mental Health Services Act (MHSA) Three Year Plans and Annual Updates. Examples of this engagement process include partnering with an experienced and local community-based organization (CBO) called Health and Human Resource Education Center (HHREC) as well as partnering with the Alameda County's Pool of Consumer Champions (Alameda's consumer run volunteer advocacy and leadership group) for outreach and marketing. These partnerships have included outreach to stakeholders through: community forums across the county; paper and online surveys; obtaining feedback at meetings where stakeholders are present; and enlistment of providers to provide feedback forums/focus groups at their locations. However, without dedicated staff capacity Alameda County struggles to reach significant population levels and specific groups due to the current political climate and lack of community connections, i.e. during the last CPP the data show the Latino community was under represented and there was limited input from the faith community, two populations that Alameda needs to hear from. The County is regularly looking to add new approaches. Most recently the County launched an MHSA Outreach Campaign which included placing billboards on buses and bus shelters. This campaign has resulted in an 88% increase in direct traffic to the County's MHSA website, which resulted in a number of community members expressing interest in joining committees. However the County continues to get feedback about the following:

- The locations and/or times of meetings not being convenient;
- Targeted populations are not suitable or target populations in need are omitted;
- Opportunities to give feedback or provide input are too few;
- The posted MHSA plans are too big to review;
- Information on how to give feedback or provide input is lacking; and
- The input received for the plan, outreach proposals, marketing, etc. was not sufficient.

APPENDIX A.

The County wishes to revitalize and improve its community planning process in order to develop a more comprehensive plan to address these concerns. Moreover, while the County has shepherded a variety of undertakings around maintaining a robust CPP, the County, as a general matter, has not consistently calculated or tracked the cost of these efforts in the Annual Revenue and Expenditure Report (ARER).

Why the Need

During the course of 2018-2019, ACBH brought five innovation plans to the commission for approval. The CPPs for each of these projects was between two (2) to five (5) years ago. The conclusion of these planning processes from several years ago, and the subsequent approval for funding, currently leaves the County absent of viable Innovations ideas.

ACBH has begun community planning for its next MHSA Three Year Plan FY 20/21-22/23. The County is acutely aware that INN Planning requires a committed amount of time and effort, as well as stakeholder input, to develop and implement projects versus other MHSA components. All Alameda County INN projects have been developed through the CPP. The process of taking stakeholder and community ideas to fruition of a completed project, requires ongoing input from stakeholders in the target populations, as well as other community members, especially those members who have lived experience and are working directly with the targeted population. These efforts require a more robust, streamlined, and continuous planning process with *dedicated staffing* than other MHSA components.

The importance of a robust CPP was recognized by the DHCS when the MHSA Innovation component was introduced in 2008-2009. Notice 08-36 states that counties could dedicate up to 25 percent of their combined 2008-2009 and 2009-2010 community program planning for Innovation. Such a percentage implies the importance of stakeholder input and reflects a higher planning burden for creating Innovation projects as compared to the other MHSA components.

The County is mindful of the importance of including stakeholders and maintaining their input for the application of developing effective INN projects. Alameda County would like to revitalize its stakeholder process to be more robust, especially in the area of seeking new INN ideas. Moreover, the County wants to be able to demonstrate that meaningful community planning has occurred and safeguard that it is representative of all of our community’s needs.

The Plan

Alameda County is requesting Commission approval to earmark use of INN funds for a fixed annual allocation for community planning activities involving stakeholders, most directly, individuals in the unserved and underserved communities of Alameda County. This annual allocation will be specific in its support of design, development and implementation of new INN ideas brought forth through the CPP. Presently, under MHSA regulations, counties may use up to 5% of their total MHSA allocation to fund community program planning, and designate positions for oversight and support.

Prior to October 2017, the DHCS Annual Revenue and Expenditure Report forms did not provide a method for reporting administrative costs for a county’s CPP. Additionally, Alameda County has not detailed

separate community program planning expenditures from its administrative costs. ACBH strives to be in alignment with MHSA regulations, and therefore seeks appropriate Commission approval to use Innovation funds for its CPP.

Alameda County is seeking approval from the MHSOAC to utilize a total of $750,000 ($150,000 per year, which is the cost of a program specialist/Innovations Coordinator) over the next five years to conduct INN-related community planning. These funds will be dedicated to redesigning a more informed, CPP that will allow the County to revitalize its current process and have a specific focus on Innovation and innovative ideas. It should be noted that Alameda currently receives approximately $3.6 million/year in INN funding; so this request is to utilize slightly less than 5% of our annual INN allocation to increase capacity and strengthen the County's CPP, with a particular emphasis on generating new Innovation ideas.

Dedicated funding for staffing to revitalize the County's INN CPP will allow the County to breathe new life into its planning processes for all areas of MHSA, but especially for INN. A revitalization will give assurances that the County is committed to bringing meaningful support in developing INN ideas and projects that are important to the community. Moreover, these dedicated funds demonstrate the County is recommitting itself to the mental health of all individuals living in Alameda County.

Alameda County will continue to use its current contractor (HHREC), along with further strengthening its relationship with the Pool of Consumer Champions for testing new stakeholder outreach methods. Additionally, Alameda will reach out to other Bay Area counties to better understand their CPP processes and how they empower the community to bring forth new INN ideas. HHREC has proven success in reaching stakeholders particularly using pathways of technology. The County hopes to tap into new methods of outreach using technology and social media as well as other ideas from our neighboring counties. The POCC will also be vital to these new increased efforts as they have their finger on the pulse of community needs. They are, to use a phrase, boots on the ground. By utilizing these resources in combination with dedicated staff capacity it's our goal to increase the CPP process and bring forward truly innovative ideas.

The County's Senior Planner for MHSA, along with the INN Coordinator will be coordinating with HHREC and the POCC to create outreach for stakeholders in a few targeted populations to ascertain which outreach models are viable and can be replicated across other populations. The targeted populations will begin with:

- Older adults (55+)
- Asian/Pacific Islanders
- Spanish speaking adults
- LGBTQ transitional age youth and adults
- African American adults and youth
- Family members of consumers
- Faith Community

The CPP design will be used to apply suggestions by the community to preserve outreach target groups for inclusion in the process. Data collected during the initial planning process will be used to determine if the

model is successful and can be replicated across other targeted populations or if the model needs adaptations in accordance to the targeted population's needs.

As the outreach model is refined, ACBH will pursue an increase in outreach to the county's more challenging populations, such as monolingual communities who do not meet the threshold language criteria but should be targeted to better understand needs and INN project ideas. Alameda County is the seventh largest county in California, and is the fourth most diverse county in the United States with thirty-two percent (32%) foreign born individuals, meaning one in ten residents is not a citizen of the United States. These factors on their own are difficult to traverse. Collectively, these factors have proven to be even more challenging when reaching rural communities, non-US citizens, and individuals with English is a second language. There are sixty-one (61)[1] different languages spoken in the county. A rather large, disparate number beyond the County's threshold languages.

ACBH is additionally seeking to gain more connections with faith based organizations. ACBH has traditionally had a strong connection, but these connections historically have been with African-American organizations. The County wishes to expand its faith based organizations to include the most recent influx of residents from Asia. Other groups the County will be attempting to engage are advocacy organizations and first responders. The county is interested in how the inclusion of these latter groups can be beneficial to the stakeholder process.

Since the Bay Area is a breeding ground of technology, ACBH is exploring how to utilize technology to enhance its outreach models. These models will be a means to engage non-mobile, isolated individuals who want to have a voice in the County's system of community input and INN design. Furthermore, technology continues to be a promising method of engagement for youth, TAY, and monolingual residents because of the prevalence of smartphones.

Budget

ACBH is requesting Commission approval and authorization to use $750,000 of INN funds for INN-related community planning over the next five years for an annual amount of $150,000/yr. This requested budget is less than 5% of ACBH's INN funding per year. As part of ACBH's plan, a dedicated INN Coordinator has been added to the County's MHSA division. This addition of a dedicated staffer brings the County more in line with MHSA regulations. Furthermore, the requested amount is the cost of 1 FTE at the program specialist level which is $100,006, plus benefits calculated at 50% for a total of $150,000. If approved these INN funds will be earmarked in the ARER for community planning.

Outcomes

ACBH is committed to its stakeholders. ACBH is also committed to observing all regulations, with transparency and transformation. The County, with a reinvigorated, robust CPP, will be able to track

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[1] http://www.acgov.org/board/bos_calendar/documents/DocsAgendaReg_02_05_19/GENERAL%20ADMINISTRATION/Regular%20Calendar/CAO_276039.pdf

specific efforts more easily. The efforts to be tracked will include, but not limited to:

- What efforts were utilized each year in community planning;
- Types of advertising utilized;
- How many community members participated;
- How many community planning events were held and when;
- Event target population(s);
- What INN projects arose through these events and activities; and
- How the County's efforts produced an INN plan that resulted in a successful approval by the Commission.

Conclusion

Alameda County will be adding this request to the County's MHSA Annual Update Fiscal Year 19/20 which will be finalized with an approval by the Alameda County Board of Supervisors in March, 2020.

APPENDIX B.

ACBH Trainings: FY18-19 **96 trainings; 105 training days; 2,842 staff trained; 422.5 CEs;**

Date	Training Title	ACBH Sponsor/ Coordinator	# Attended	CEs	Location	Audience
7/17/2018	Clinical Documentation Training for Clinician's Gateway-Electronic Health Record (EHR) Users	QA	28	5.0	Oakland, 2000 Embarcadero, Joaquin M	Clinical staff
7/27/2018	Treatment & Beyond: Improving Retention and Treatment Outcomes for African Americans through Effective Case Management	Ethnic Services	46	5.5	Oakland, 2000 Embarcadero, Gail Steele	All staff
8/1/2018	Mental Health Providers (MHP) Network Providers Clinical Documentation Standards Training	QA	25	5.0	Oakland, 2000 Embarcadero, Joaquin M.	MH Plan Providers
8/15/2018	Supporting Children of Incarcerated Parents: Breaking the Silence, Making a Difference	HCSA-Center for Healthy Schools & Communities (CHSC)/ Tuere Anderson	33	6.0	San Leandro, REACH	HCSA-All CHSC staff
8/17/2018	Clinical Documentation Standards Training "Train the Trainer" for Master Contract Providers Training	QA	26	5.0	Oakland, 2000 Embarcadero, Joaquin M	Providers -Clinical staff
8/23/2018	Consent, Confidentiality, and Behavioral Health for Youth in Foster Care	Office of Medical Director	26	2.0	Oakland, 2000 Embarcadero, Gail Steele	Clinical staff
8/24/2018	ASAM-A	SUDSOC	49	5.5	Oakland, 1900 Embarcadero, Brooklyn B	SUD Providers
9/14/2018	Supporting Children of Incarcerated Parents…	HCSA-CHSC/Tuere Anderson	25	3.0	San Leandro, 1000 S.L.Blvd;	Youth & Family Orgs
9/18/2018	Supporting Children of Incarcerated Parents: Breaking the Silence, Making a Difference	HCSA-CHSC/Tuere Anderson	33	3.0	San Leandro, 500 Davis St	School-based Hlth Center Staff
9/19/2018	Supporting Children of Incarcerated Parents: Breaking the Silence, Making a Difference	HCSA-CHSC/Tuere Anderson	9	3.0	San Leandro, Barbara Lee Health Ctr., Bancroft Ave	School District Staff
9/26/2018	Suicide Assessment & Intervention	Training Unit/CSS	48	3.0	San Leandro, Creekside - Redwood Rm	All staff
9/28/2018	BHCS Supporting Children of Incarcerated Parents; Breaking the Silence, Making a Difference (3 Hrs)	HCSA-CHSC/Tuere Anderson	12	3.0	San Leandro, 500 Davis St	School-Based Behavioral Health Staff
10/2/2018	Adult MHFA	Training Unit/CSS	25	0.0	Oakland, 1900 Embarcadero, Brooklyn B	All staff

APPENDIX B.

Date	Training Title	ACBH Sponsor/ Coordinator	# Attended	CEs	Location	Audience
10/3/2018	BHCS QA: Clinician Gateway-EHR Clinical Documentation Training	QA	29	5.0	Oakland, 2000 Embarcadero, Joaquin M	Clinical staff
10/10/2018	QA: Clinical Doc & Auth for SUD Tx; Organized Delivery System (ODS) Requirements	QA	42	5.0	Oakland, 2000 Embarcadero, Joaquin M	SUD Providers
10/12/2018	CFT Facilitation Training	CYASOC/Andrea Kiefer	10	6.0	Oakland, 1900 Embarcadero, Brooklyn B	ICC Coordinators
10/12/2018	Adult MHFA (for Housing)	Housing/Robert Ratner	24	0.0	Oakland, 2000 Embarcadero, Joaquin M	Housing staff
10/15/2018	Youth MHFA (10/15 & 10/16 - 1/2 day each)	CYASOC/Lisa Carlisle	16	0.0	Oakland, 1900 Embarcadero, Brooklyn B	Family Partners
10/15/2018	Brief Tobacco Cessation Intervention	ATOD/Patricia Lopez	9	3.5	Oakland, 2000 Embarcadero, Gail Steele	All staff
10/16/2018	BHCS QA: Mental Health Plan (MHP) Fee-for-Service Providers Clinical Documentation Standards	QA	41	5.0	Oakland, 2000 Embarcadero, Joaquin M	MH Plan Providers
10/18/2018	TCOM Training for Trainers (CANS/ANSA)	Jen Cardenas	18	5.5	Oakland, 2000 Embarcadero, Joaquin M	Certified CANS/ANSA Users
10/23/2018	Cultural & Clinical Factors Affecting Retention of AfAm in SUD Tx Programs	Ethnic Services	53	4.5	Oakland, 1900 Embarcadero, Brooklyn B	SUD Providers
10/24/2018	Eating D/O & D/O Eating: What to Do	CYASOC/Sun Lee	14	3.0	Oakland, Eastmont	Clinical staff
11/7/2018	Suicide Assessmt & Intrvtn (Santa Rita staff only)	AFBH/Yvonne Jones	18	3.0	Dublin, Santa Rita	Santa Rita staff
11/7/2018	Eating D/O & D/O Eating: What to Do	CYASOC/Sun Lee	11	3.0	Fremont, Fremont Family Resource Ctr.	Clinical staff
11/8/2018	Clinical Documentation Standards Training "Train the Trainer" for Master Contract Providers Training	QA	24	5.0	Oakland, 2000 Embarcadero, Joaquin M	Providers -Clinical staff
11/9/2018	Strong, Brown & Proud-Genesis of the Latinx Raza…	Ethnic Services	46	4.5	Oakland, 1900 Embarcadero, Brooklyn B	All staff
11/9/2018	Adult MHFA (for Housing only)	Housing/Robert Ratner	14	0.0	Oakland, 2000 Embarcadero, Joaquin M	Housing staff
11/28/2018	Law & Ethics - HIPAA, Minor Consent, & 42CFR Part II (ACBH & Public Health)	Training Unit	96	6.0	Oakland, Cal Endowment	ACBH & PH
11/29/2018	Benefit Engagement as a Continuous Quality Improvement Strategy for Improving Services to African Americans	Ethnic Services	22	5.5	Oakland, 2000 Embarcadero, Gail Steele	All staff
11/29/2018	Asian & Pacific Islander (API) Statewide Conference; 11/29 & 11/30 (500 attended day 1; 350 day 2; 3 CEs day 1, 1 CE day 2)	QI/Sophia Lai	500	3.0	Oakland, Hilton Oakland Airport	All staff

APPENDIX B.

Date	Training Title	ACBH Sponsor/ Coordinator	# Attended	CEs	Location	Audience
11/30/2018	Asian & Pacific Islander (API) Statewide Conference; 11/29 & 11/30 (500 attended day 1; 350 day 2; 3 CEs day 1, 1 CE day 2)	QI/Sophia Lai	350	1.0	Oakland, Hilton Oakland Airport	All staff
12/4/2018	Dynamic Mindfulness (1-day only, No CEs)	CYASOC/Colleen Sanford	18	0.0	Oakland, 1900 Embarcadero, Brooklyn B	All staff
12/5/2018	Youth MHFA	Training Unit	22	0.0	Oakland, 1900 Embarcadero, Brooklyn B	All staff
12/11/2018	Listening to the Silence: Asian American Cultural Competency in Culture	Ethnic Services	44	5.5	Oakland, 1900 Embarcadero, Brooklyn B	All staff
1/7/2019	"From Color-Blindness to Cultural Humility and Cultural Competence: Understanding Whiteness and Its Implications for Health Equity Training"	Ethnic Services	48	5.5	Oakland, 2000 Embarcadero, Gail Steele	All staff
1/9/2019	Adult MHFA	Training Unit/CSS	29	0.0	San Leandro, Creekside - Redwood Rm	All staff
1/22/2019	HANDLE Approach to Neurodevelopment; Introductory Course, Levels I&II (2-day 1/22 & 1/23; 13 CEs for both days, no partial)	CYASOC/Catherine Franck			Oakland, 1900 Embarcadero, Brooklyn B	Clinical staff
1/23/2019	Dismantling Implicit Bias and Healing Racial Trauma	Ethnic Services	119	4.5	Oakland, AC Learng Ctr-Oaklnd Rm	All staff
1/23/2019	HANDLE Approach to Neurodevelopment; Introductory Course, Levels I&II (2-day 1/22 & 1/23; 13 CEs for both days, no partial)	CYASOC/Catherine Franck	14	13.0	Oakland, 1900 Embarcadero, Brooklyn B	Clinical staff
1/26/2019	CSUEB Infant & Early Childhood Mental Health Program (1st Sem)	Early Childhood/ Margie Padilla	15	60.0	Online; CalState East Bay	Clinical staff
1/29/2019	Motivational Interviewing (2-day; 1/29 & 1/30; 12 CEs)	Training Unit/ Seneca			Oakland, Holy Redeemer Center	All staff
1/29/2019	Adult MHFA (for Housing)	Housing/Robert Ratner	13	0.0	Oakland, 2000 Embarcadero, Joaquin M	Housing staff
1/30/2019	Motivational Interviewing (2-day; 1/29 & 1/30;12 CEs)	Training Unit/ Seneca	20	12.0	Oakland, Holy Redeemer Center	All staff
2/1/2019	Youth MHFA (in SPANISH) Pilot: 5-10 staff	CYASOC/Dulce Lopez	9	0.0	San Leandro, Creekside, 500 Davis St	All Spanish spkg
2/6/2019	BHCS QA: Clinical Documentation for SUD Tx; (ODS) OS/IOS/RES	QA	44	5.0	Oakland, 2000 Embarcadero, Joaquin M	SUD Providers
2/8/2019	Co-Occurring Disorders in Addiction, Part 1 of 3 (Dr. Rob Lee)	Training Unit & Rob Lee	54	2.5	Oakland, 2000 Embarcadero, Gail Steele	SUD Providers
2/13/2019	CANS/ANSA Training for Trainers	Jen Cardenas	17	5.5	San Leandro, Creekside, 500 Davis St	Certified CANS/ANSA Users

APPENDIX B.

Date	Training Title	ACBH Sponsor/ Coordinator	# Attended	CEs	Location	Audience
2/13/2019	BHCS QA: Clinical Documentation Standards 'Train the Trainer' for Master Contract Providers	QA	27	5.0	Oakland, 2000 Embarcadero, Joaquin M	Providers -Clinical staff
2/15/2019	Caught in the Crossfire of Cultures-Part I	Ethnic Services	11	4.0	Fremont, Fremont Family Resource Ctr.	Providers-Afghan Immigrant Population
2/21/2019	Youth MHFA	Training Unit/CSS	19	0.0	San Leandro, Creekside - Redwood Rm	All staff
2/22/2019	Preventing, De-Escalating, and Managing Aggressive Behavior in Behavioral Health Settings	Training Unit/ Seneca	35	5.5	Santa Rita, Dublin	All staff
2/25/2019	Dynamic Mindfulness- 1 day ONLY (no CEs)	CYASOC/Colleen Sanford	10	0.0	San Leandro, Creekside - Redwood Rm	All staff
2/26/2019	Dynamic Mindfulness 2-day 2/25 & 2/26 (11.5 CEs)	CYASOC/Colleen Sanford	26	11.5	San Leandro, Creekside - Redwood Rm	Clinical staff
2/27/2019	Preventing, De-Escalating, and Managing Aggressive Behavior in Behavioral Health Settings	Training Unit/ Seneca	48	5.5	Oakland, Seneca 6925 Chabot Road,	All staff
3/1/2019	Caught in the Crossfire of Cultures-Part I (repeated)	Ethnic Services	3	4.0	Oakland, 2000 Embarcadero, Gail Steele	Providers-Afghan Immigrant Population
3/5/2019	Tobacco Treatment Specialist Core Training (4-day: 3/5,6,12, and 13; 22.5 CEs)	ATOD/Patricia Sanchez			Oakland, 1900 Embarcadero, Brooklyn B	All staff
3/6/2019	SOGI -Sexual Orientation and Gender Identity: Working with Transgender and Non-Binary Populations (4-part series)	MHSA/Kelly Robinson/ Pacific Ctr	9	6.0	Oakland, 2000 Embarcadero, Gail Steele	All staff
3/6/2019	Tobacco Treatment Specialist Core Training (4-day: 3/5,6,12, and 13)	ATOD/Patricia Sanchez			Oakland, 1900 Embarcadero, Brooklyn B	All staff
3/8/2019	BHCS QA: Clinician Gateway-EHR Clinical Documentation Training	QA	16	5.0	Oakland, 2000 Embarcadero, Joaquin M	Clinical staff
3/8/2019	Co-Occurring Disorders in Addiction, Part 2 of 3 (Dr. Rob Lee)	Training Unit & Rob Lee	43	2.5	Oakland, 2000 Embarcadero, Gail Steele	SUD Providers
3/12/2019	Tobacco Treatment Specialist Core Training (4-day: 3/5,6,12, and 13)	ATOD/Patricia Sanchez			Oakland, 1900 Embarcadero, Brooklyn B	All staff
3/13/2019	Tobacco Treatment Specialist Core Training (4-day: 3/5,6,12, and 13)	ATOD/Patricia Sanchez	12	22.5	Oakland, 1900 Embarcadero, Brooklyn B	All staff
3/18/2019	Brief Tobacco Cessation Intervention Training	ATOD/Alex Hay	10	3.5	Oakland, 2000 Embarcadero, Gail Steele	All staff

APPENDIX B.

Date	Training Title	ACBH Sponsor/ Coordinator	# Attended	CEs	Location	Audience
3/19/2019	Beyond Labels: An Introduction to the HANDLE Approach (2-day)	CYASOC/Catherine Franck			San Leandro, Juniper St	Clinical staff
3/19/2019	Adult MHFA	Training Unit/CSS	30	0.0	Fremont, Family Family Resource Ctr	All staff
3/20/2019	Beyond Labels: An Introduction to the HANDLE Approach (2-day)	CYASOC/Catherine Franck	17	13.0	San Leandro, Juniper St	Clinical staff
3/20/2019	QA-Clinical Documentation Standards training for MH Plan Fee-for-Service Providers	QA	16	5.0	Oakland, 2000 Embarcadero, Joaquin M	MH Plan Providers
3/22/2019	Caught in the Crossfire of Cultures-Part II	Ethnic Services	13	4.0	Oakland, 1900 Embarcadero, Brooklyn B	Providers-Afghan Immigrant Population
4/2/2019	Youth MHFA	Training Unit/CSS	11	0.0	Fremont, Fremont Family Resource Ctr	All staff
4/4/2019	Clinical Supervision (2-day; 4/4 & 4/5/19)	Training Unit/ABW			Oakland, 1900 Embarcadero, Wildcat C.	Clinical staff
4/5/2019	Clinical Supervision (2-day; 4/4 & 4/5/19)	Training Unit/ABW	13	15.0	Oakland, 1900 Embarcadero, Wildcat C.	Clinical staff
4/11/2019	BEHAVIORAL HEALTH INTERPRETER TRAINING (2-day; 4/11 & 4/12/19)	Ethnic Services			Oakland, 1900 Embarcadero, Brooklyn B	All staff
4/11/2019	Conference: From Surviving to Thriving: Older Adults & Trauma Informed Care	AOASOC/Ofra Paz	40	3.0	Alameda, Alameda Alliance for Health	All staff
4/12/2019	BEHAVIORAL HEALTH INTERPRETER TRAINING (2-day; 4/11 & 4/12/19)	Ethnic Services	11	0.0	Oakland, 1900 Embarcadero, Brooklyn B	All staff
4/12/2019	Co-Occurring Disorders in Addiction, Part 3 of 3 (Dr Rob Lee)	Training Unit & Rob Lee	41	2.5	Oakland, 2000 Embarcadero, Gail Steele	SUD Providers
4/15/2019	Seeking Safety: an EBP for Trauma and/or SUD	Training Unit/ Seneca	62	5.5	San Leandro, Creekside - Redwood Rm	All staff
4/17/2019	5150/5585 certification (for CRP only)	AODSOC/ Stephanie Lewis	13	6.5	Hayward, 409 Jackson St	CRP staff
4/18/2019	19th Annual SIPP Forum (Senior Injury Prevention Program)	HCSA EMS/Carol Powers	17	3.0	Oakland, Lincoln Ave	HCSA Older Adult staff
4/22/2019	Preventing Vicarious Trauma: Beverly Kyer	Training Unit/ABW	45	6.0	San Leandro, Creekside - Redwood Rm	All staff
4/24/2019	QA-Clinical Documentation for SUD Res Providers	QA	23	5.0	Oakland, 2000 Embarcadero, Joaquin M	SUD Providers

APPENDIX B.

Date	Training Title	ACBH Sponsor/ Coordinator	# Attended	CEs	Location	Audience
4/26/2019	Caught in the Crossfire of Cultures-Part III	Ethnic Services	6	4.0	Oakland, 2000 Embarcadero, Gail Steele	Providers-Afghan Immigrant Population
4/29/2019	HANDLE Approach to Neurodevelopment; Introductory Course, Levels I&II (2-day; 4/29 & 4/30/19)	CYASOC/Catherine Franck			Oakland, 2000 Embarcadero, Gail Steele	Clinical staff
4/30/2019	HANDLE Approach to Neurodevelopment; Introductory Course, Levels I&II (2-day; 4/29 & 4/30/19)	CYASOC/Catherine Franck	29	14.0	Oakland, 2000 Embarcadero, Gail Steele	Clinical staff
5/3/2019	Caught in the Crossfire of Cultures-Part IV	Ethnic Services	5	4.0	Oakland, 2000 Embarcadero, Gail Steele	Providers-Afghan Immigrant Population
5/8/2019	The Impact of Parental Incarceration on Children in the Child Welfare System	CYASOC/Damon Eaves	77	5.5	Oakland, Cal Endowment	All staff
5/8/2019	BHCS QA: Clinical Documentation Standards 'Train the Trainer' for Master Contract Providers	QA	22	5.0	Oakland, 2000 Embarcadero, Joaquin M	Providers -Clinical staff
5/10/2019	Child & Family Team (CFT) Facilitation (by Invitation ONLY)	CYASOC/Andrea Kiefer	8	6.0	Oakland, 1900 Embarcadero, Brooklyn B	ICC Coordinators
5/15/2019	BHCS QA: Clinician Gateway-EHR Clinical Documentation Training	QA	12	5.0	Oakland, 2000 Embarcadero, Joaquin M	Clinical staff
5/16/2019	QM/SUD: Clinically Meaningful SUD Treatment & Documentation; (2-day 5/16 & 6/7; see end date of 6/7 for # of attendees, CEs)	QA/Sharon Loveseth			Oakland, 2000 Embarcadero, Gail Steele	SUD Providers
5/22/2019	Positive Behavioral Interventions for Children and Youth	Training Unit/ Seneca	20	3.5	Oakland, 1900 Embarcadero, Brooklyn B	Clinical staff
5/23/2019	Trauma Informed Care- Beyond the Basics	Training Unit/ABW	30	4.0	Berkeley, Adeline at ABW	Clinical staff
5/24/2019	Caught in the Crossfire of Cultures-Part V	Ethnic Services	7	4.0	Oakland, 2000 Embarcadero, Gail Steele	Providers-Afghan Immigrant Population
5/29/2019	Law & Ethics (Daniel Taube J.D., Ph.D.)	Training Unit/ABW	23	6.0	Dublin, Santa Rita	Clinical staff
6/4/2019	QA-Clinical Documentation Standards training for MH Plan Fee-for-Service Providers	QA	10	5.0	Oakland, 2000 Embarcadero, Joaquin M	MH Plan Providers

APPENDIX B.

Date	Training Title	ACBH Sponsor/ Coordinator	# Attended	CEs	Location	Audience
6/5/2019	CANS/ANSA Training for Trainers	CYASOC/ Christine Mukai	5	5.5	Oakland, 2000 Embarcadero, Gail Steele	Certified CANS/ANSA Users
6/7/2019	Caught in the Crossfire of Cultures-Part V	Ethnic Services	9	4.0	Fremont, Fremont Family Resource Ctr	Providers-Afghan Immigrant Population
6/7/2019	QM/SUD: Clinically Meaningful SUD Treatment & Documentation; (2-day 5/16 & 6/7; see end date of 6/7 for # of attendees, CEs)	QA/Sharon Loveseth	38	12.0	Oakland, 2000 Embarcadero, Gail Steele	SUD Providers
6/11/2019	Brief Tobacco Cessation Intervention Training	ATOD/Alex Hay	9	3.5	Oakland, 2000 Embarcadero, Gail Steele	All staff
6/20/2019	Behavioral Health & Criminal Justice (6/20/19 and 6/21/2019; 6 CEs for both days, 12-4pm)	QI/Sophia Lai	45	3.0	Oakland, 2000 Embarcadero, Brooklyn Basin & Joaquin Miller	All staff
6/21/2019	Behavioral Health & Criminal Justice (6/20/19 and 6/21/2019; 6 CEs for both days, 12-4pm)	QI/Sophia Lai	33	3.0	Oakland, Embarcadero, Brooklyn B & Joaquin M	All staff
6/24/2019	Vaping Nicotine: How safe is it for our communities?	ATOD/ Alex Hay	31	4.0	Oakland, Oakland Museum of CA	All staff
6/26/2019	Dreams-Clinical Utilization in a Correctional Setting (for AFBH Only)	AFBH/Yvonne Jones	20	2.0	Dublin, Santa Rita	AFBH staff
6/26/2019	Impacto del Trauma de la Inmigración en las Familias: Cómo se manifiesta y estrategias para apoyar a niños/as y familias Latinas (Traumatic Impact of Immigration on Children and Families) Training in SPANISH	CYASOC/Libby Higgins	45	4.0	San Leandro, Creekside, 500 Davis St	All Spanish spkg
6/28/2019	Introduction to SBIRT (Screening, Brief Intervention, and Referral for Treatment) with MI (Motivational Interviewing) Skill Building	Training Unit/ABW	55	6.0	Oakland, 2000 Embarcadero, Gail Steele	Clinical staff
	105 Training days; Actual trainings: 96 (eight 2-day & one 4-day)	***TOTALS***	***2,842***	***422.5***		

APPENDIX C.

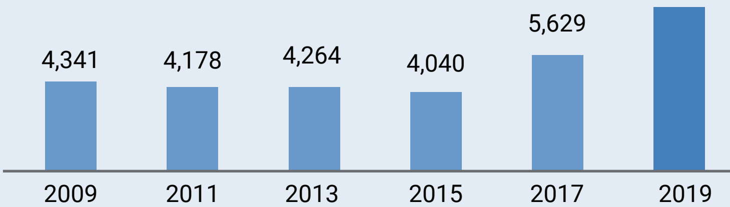
Alameda County

2019 EveryOne Counts Homeless Point-in-Time Count & Survey

Every two years, during the last 10 days of January, communities across the country conduct comprehensive counts of people experiencing homelessness in order to measure the prevalence of homelessness in each local community.

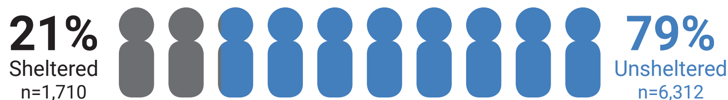
The 2019 Alameda County EveryOne Home Point-in-Time Count was a community-wide effort conducted on January 30th, 2019. In the weeks following the street count, a survey was administered to **1,681** unsheltered and sheltered individuals experiencing homelessness in order to profile their experience and characteristics.

Homeless Census Population



Sheltered/ Unsheltered Population

21% Sheltered n=1,710



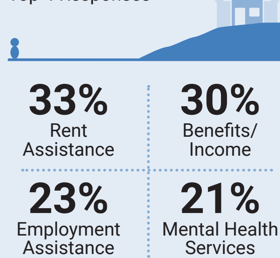
79% Unsheltered n=6,312

Duration of Current Episode of Homelessness

5%	24%	63%
30 Days or Less	1-11 Months	1 Year or More

What Might Have Prevented Homelessness

Top 4 Responses

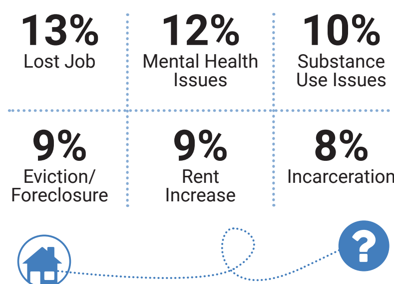


33% Rent Assistance	**30%** Benefits/ Income
23% Employment Assistance	**21%** Mental Health Services

Primary Causes of Homelessness

Top 6 Responses

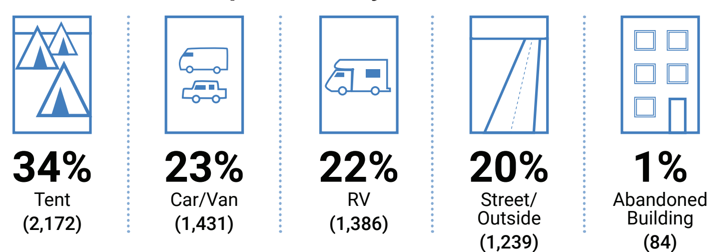
13% Lost Job	**12%** Mental Health Issues	**10%** Substance Use Issues
9% Eviction/ Foreclosure	**9%** Rent Increase	**8%** Incarceration



Sheltered/Unsheltered Population by City

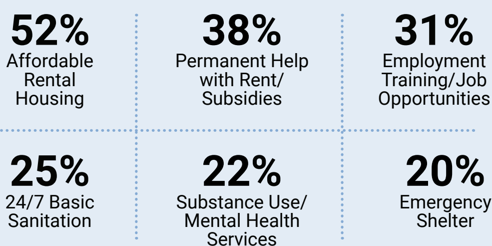
City	Sheltered	Unsheltered
Alameda	99	132
Newark	30	59
Albany	0	35
Oakland	861	3,210
Berkeley	295	813
Piedmont	0	0
Dublin	0	8
Pleasanton	0	70
Emeryville	0	178
San Leandro	74	344
Fremont	123	485
Unincorporated	28	321
Hayward	115	372
Union City	0	106
Livermore	85	179
Total	**1,710**	**6,312**

Unsheltered Population by Location



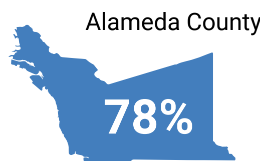
34%	23%	22%	20%	1%
Tent (2,172)	Car/Van (1,431)	RV (1,386)	Street/ Outside (1,239)	Abandoned Building (84)

How New Money Should Be Spent



52% Affordable Rental Housing	**38%** Permanent Help with Rent/ Subsidies	**31%** Employment Training/Job Opportunities
25% 24/7 Basic Sanitation	**22%** Substance Use/ Mental Health Services	**20%** Emergency Shelter

Residence Prior to Homelessness

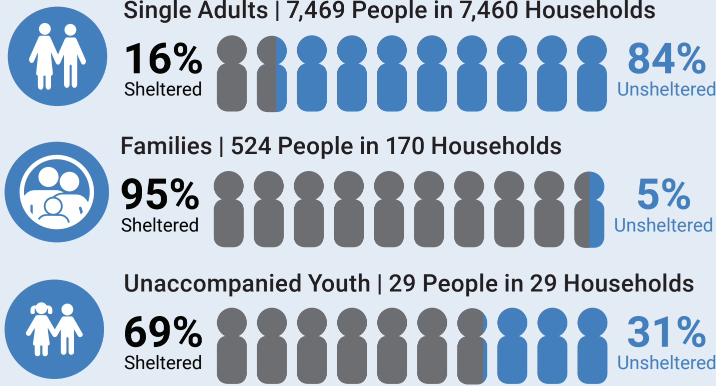


Length of Time in Alameda County

57% 10 Years+	**13%** 5-9 Years
13% 1-4 Years	**12%** < 1 Year

ASR

Household Breakdown

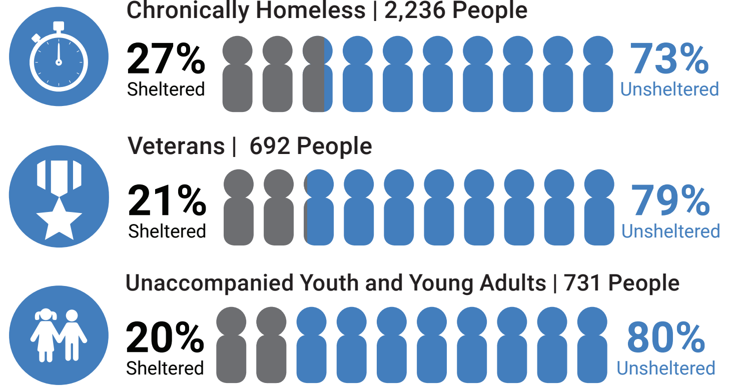


Single Adults | 7,469 People in 7,460 Households
16% Sheltered | 84% Unsheltered

Families | 524 People in 170 Households
95% Sheltered | 5% Unsheltered

Unaccompanied Youth | 29 People in 29 Households
69% Sheltered | 31% Unsheltered

Subpopulations

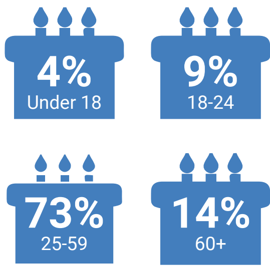


Chronically Homeless | 2,236 People
27% Sheltered | 73% Unsheltered

Veterans | 692 People
21% Sheltered | 79% Unsheltered

Unaccompanied Youth and Young Adults | 731 People
20% Sheltered | 80% Unsheltered

Age

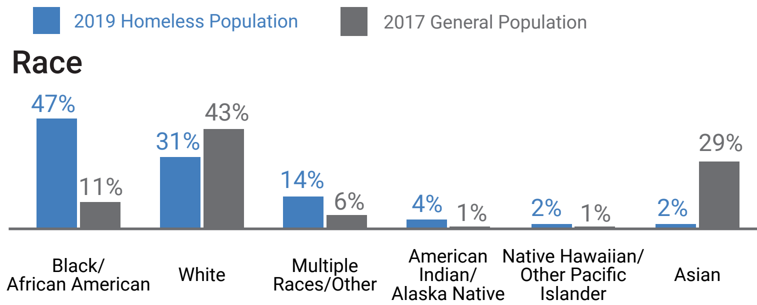


- 4% Under 18
- 9% 18-24
- 73% 25-59
- 14% 60+

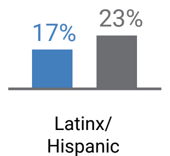
LGBTQ+ Status

14% of survey respondents identified as LGBTQ+.

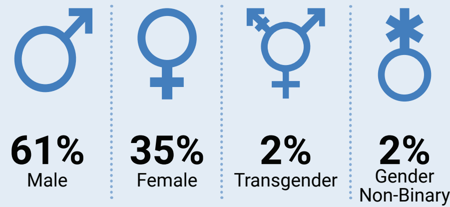
Race and Ethnicity Compared to General Population



Ethnicity



Gender



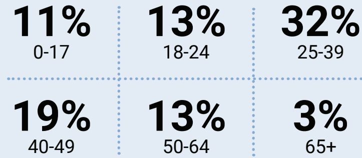
- 61% Male
- 35% Female
- 2% Transgender
- 2% Gender Non-Binary

First Episode of Homelessness

31% Yes

62% of those experiencing homelessness for the first time were homeless for one year or more.

Age at First Episode of Homelessness



11% 0-17	13% 18-24	32% 25-39
19% 40-49	13% 50-64	3% 65+

Not Interested in Housing

3% of survey respondents said they were not interested in Independent, Affordable Rental Housing or Housing with Supportive Services.

Health Conditions+

Current health conditions reported by survey respondents.

39% Psychiatric/ Emotional Conditions

30% Alcohol & Drug Use

30% Post-Traumatic Stress Disorder

26% Chronic Health Problems

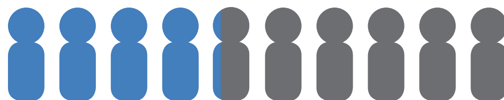
24% Physical Disability

13% Traumatic Brain Injury

5% HIV/ AIDS Related Illness

Disabling Conditions

42% of survey respondents reported having at least one disabling condition.



A disabling condition is defined by HUD as a developmental disability, HIV/ AIDS, or a long-term physical or mental impairment that impacts a person's ability to live independently, but could be improved with stable housing.

For definitions, additional information on methodology or efforts to address homelessness, visit www.everyonehome.org.
Alameda County will release a comprehensive report of the 2019 EveryOne Home Homeless Count and Survey in Summer 2019. For more information about EveryOne Home and efforts to address homelessness in Alameda County please visit www.EveryOneHome.org
Source: Applied Survey Research, 2019, Alameda EveryOne Home Homeless Count & Survey, Watsonville, CA.

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