innovation

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asian community mental health services

Asian Community
Mental Health Services

Project Asian Reach

BHCS
ALAMEDA COUNTY
Behavioral Health Care Services

MENTAL HEALTH SERVICES ACT
PROPOSITION 63
CALIFORNIA

Asian Community Mental Health Services

Project Asian Reach

OUR STORY

For 41 years, Asian Community Mental Health Services has provided multilingual and multicultural services to enable the most vulnerable to lead healthy, productive and contributing lives. Project Asian Reach is an important opportunity for us to try out creative and culturally responsive strategies to reach underserved, isolated, monolingual Cantonese, Mandarin and Korean-speaking adults and older adults who are struggling with mental health challenges. Asian communities comprise 27% of Alameda County's population with the number of older adults on the rise. Language and cultural barriers, and stigma prevent many Asian immigrants and refugees from reaching out to seek help. There is a great need to develop an increased workforce of bilingual, bi-cultural clinicians and peers in order to effectively engage underserved Asian communities.

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ROUND THREE INNOVATION GRANT

Isolated Adult & Older Adult Consumers

INN 3 GRANTEE DESIRED OUTCOME

Date Submitted: November 9, 2015

Project Name: Project Asian Reach (PAR)

Grantee Organization: Asian Community Mental Health Services (ACMHS)

Project Author: Esther Chow

LEARNING QUESTIONS

1. Our project addressed the following two learning questions:

*   (Question 1): Can the use of trained peers or family members of consumers for home-based outreach to socially isolated adults and older adults with serious mental illness reduce their isolation through relationship building?

*   (Question 4): Can a place-based outreach program by trained peers to public locations in the community, such as parks, coffee shops, and libraries where otherwise isolated persons may go, be effective in reducing social isolation and increasing participation in mental health services among isolated adults and older adults with serious mental illness?

2. To address **learning question 1**, our project employed three teams of bilingual, bicultural clinician and peer mentor interns to launch home-based outreach to monolingual Chinese and Korean-speaking isolated adults and older adults who experienced mental health challenges. Each team consisted of one 0.5FTE licensed or license-track mental health clinician and two peer mentors who were involved one to two days per week. Two teams speak Cantonese and Mandarin. One team speaks Korean.

    Our answer to learning question 1 is **"Yes"** based on our project findings which will be shared in detail in **Section 6.** In short, we found the bilingual, bicultural team of clinician

and peer mentor was effective in reducing isolation of our target populations by building trusting relationship with participants over time. However, not many of our participants have "serious mental illness." The majority of them suffer from mild to moderate depression as a result of grief and losses: Loss of spouse, loved ones and friends as they age. In addition, some suffer from mild to moderate anxiety and depression due to their deteriorating health and mobility, and infrequent contact with their adult children.

To address **learning question 4**, the same teams did periodic place-based outreach in public places frequently visited by Chinese and Korean individuals who may be isolated, such as Oakland Library Asian Branch in Oakland Chinatown's Pacific Renaissance Plaza, Koreana Plaza Grocery Store on Telegraph, and many Korean churches in the East Bay. Through these periodic place-based outreach efforts, we connected a total of 13 individuals to prevention, early intervention or treatment mental health services according to their needs.

We found this place-based outreach strategy **not quite effective** in reducing social isolation or increasing participation in mental health services. One reason was the difficulty of building a longer term, trusting relationship during these periodic outreach efforts. There was the lack of privacy to have deep conversations. It seemed many people were reluctant to talk with strangers they met for the first time in a public setting. Therefore in the middle of our project, we tried out a modified approach for place-based outreach by targeting several senior housing facilities as the locations of our place-based outreach. By first establishing a relationship with the social services coordinator or housing manager on-site, our team built a bridge to gain access and trust to the residents. (See Section 3 below)

3. In collaboration with our agency's prevention staff, we offered an **8-week Art and Wellness Group** for senior residents in three apartment buildings in Oakland. Two of these are senior housing with a significant number of monolingual Chinese and Korean residents but offer little social recreation activities on-site. We visited and built relationship with the social service coordinators and presented our proposed free group activity for their residents. Our Art and Wellness groups were co-led by our bilingual Chinese and Korean clinician and teaching artist consultant. The third apartment complex located in Oakland Chinatown is not a senior housing but has a significant number of Chinese seniors who are isolated according to the housing manager. The social service coordinators and housing manager welcomed our intervention by offering free space on-site and assistance in publicizing the wellness group by disseminating our

flyers printed in English, Chinese and Korean languages to their residents (See Appendix 11). As a result, each group held respectively in South Lake Tower, Westlake Christian Terrace and City Center Plaza had 6-12 active participants. A majority reported feeling positive, joyful, increased self-esteem and increased social connection upon their completion of the 8-week Art and Wellness Group. They did not want the group to end but desired to have such ongoing wellness group activities

Another intervention we employed was a **Lunar New Year Cultural Celebration** for all home-based outreach participants at our Oakland Chinatown office location (See Appendix 10). We provided cultural decorations and entrees and asked participants to voluntarily bring cultural New Year snacks, side dishes or desserts. We encouraged staff and participants to wear their respective cultural New Year outfits. We celebrated by having the Chinese group and the Korean group sing cultural New Year songs in their respective languages. One Chinese elderly man did Chinese calligraphy demonstration with brush and wrote traditional Chinese New Year blessings on special red paper (Chinese cultural color of happiness and New Year) for participants to take home. Participants who were physically mobile with available transportation were able to attend. They shared a joyous time and felt a sense of renewed cultural pride and social connectedness.

PROGRAM DESIGN

4. The goals of our program are to utilize teams of bilingual clinician and peer mentor to reach isolated monolingual Chinese and Korean adults and older adults who may be struggling with serious mental illness. Through home-based and place-based outreach, we seek to build relationship to reduce their social isolation, offer emotional support, provide screening and periodic assessment, and refer them to helpful community resources, including mental health treatment as needed.

5. Program Design and Components:

   - **Outreach** – We began outreach by designing a bilingual Chinese program flyer and a bilingual Korean program flyer to publicize our home-based program. These flyers are 2-sided, with one side in either Chinese or Korean and one side in English. (See Appendix 1). Color flyers were printed and distributed to senior centers, senior housing, community-based agencies, and health clinics serving large populations of Chinese and Koreans such as Family Bridges' Hong Lok and Hong Fook Centers, Korean Community Center of the East Bay, Korean American Senior Center, Asian Health Services and San Antonio Neighborhood Health

Center. Electronic copies of our flyers were also sent via email to a network of providers, consumers and family member organizations such as ACBHCS, GART, POCC Asian American Committee, PEERS, NAMI South Alameda County Chinese Chapter. In addition, paid advertisements using the flyer design were published for several months in the local Chinese and Korean newspapers such as Sing Tao Daily, Herald Monthly, Korean Times, Korea Daily and Korean Christian Times. We also conducted place-based outreach using our program flyers by visiting many Korean churches in the East Bay, Oakland Library Asian Branch and Koreana Grocery Market. Initial outreach were performed by all project staff including project director, clinician supervisor, clinicians and peer mentors to get the word out.

- **Engagement** – Our clinicians are the ones who began the engagement process with interested individuals who called as a result of seeing our program flyer or who were referred by family members or providers. Our clinician first performed a brief phone screening, explained our Innovation home-based program, and then proceeded to schedule an initial home visit if the caller was open to receiving visitors. We also offered the flexibility of meeting the participants in the community if they do not feel comfortable receiving strangers in their home. For example, some participants preferred to meet in the lobby of their senior building or a nearby café. The fact that our clinician speak Cantonese, Mandarin or Korean language and have understanding of Chinese or Korean culture was a key factor in building the rapport and trust with potential participants. A clinician and one peer mentor tried to make the initial visit together. Alternatively, if an inquirer did not wish to participate in our home-based outreach program but was interested in our organization ACMHS' other mental health services such as prevention support groups, early intervention (individualized short-term counseling), our clinician was ready to connect them with such desired services that are provided by other bilingual clinicians at ACMHS office.

- **Interventions** – When a participant feels comfortable to sign a consent (Appendix 4) to receive home-based (or community-based) outreach visits on a regular basis, intervention begins. As part of the initial screening and getting to know the participant, our clinician administers the pre-test survey questionnaire to assess the level of social isolation of each participant and to find out his/her interests/hobbies (See Appendix 5). In addition, the clinician also utilizes an Initial Screening Tool (See Appendix 6) to assess the participant's mental health needs. If the participant is stable, the clinician will have the peer mentor to

schedule subsequent social visits with the participant according to the participant's schedule and preference. It is explained to the participants that peer mentors are our trained volunteers and they will visit in pair also. The primary purpose for peer mentors' visits was to build relationship with the participants, increase their socialization, and encourage participation in recreational activities or hobbies.

- **Referral to Mental Health Treatment** – During the initial screening visit and subsequent periodic visits, if there is a need to refer to mental health treatment, the clinician will discuss the need and process options with the participant. For example, one Chinese participant, during the course of home-based visits, experienced increasing suicidal thoughts. Our clinician, who has already built a trusting relationship with her, encouraged her to seek mental health treatment with medication support. A key to her acceptance was the fact that the same clinician was available to continue seeing her and our organization ACMHS was equipped with a continuum of mental health services from prevention to treatment. So it was a smooth transition to more intense mental health services for this participant.

- **Connecting to Community Resources** – Because our Innovation project was time-limited (18 months from start to finish and essentially less than 12 months of client contact), connecting our home-based outreach participants to helpful and ongoing community resources was an essential step before termination. Appendix 12 contains a list of community resources our project staff attempted to connect participants before termination according to their needs and geographic area of residence in Alameda County.

- **Evaluation** – Post-test questionnaire was completed with each participant during the last home visit and results were compared with the respective participant's Pre-test questionnaire. Data analysis was performed to evaluate if our program made a difference in reducing social isolation of participants and connecting them to needed mental health services. Findings are explained below (Section 6).

6. How did the program impact the population served by this project?

We attempted to measure our home-based outreach program's impact by administering a pre-test survey questionnaire with each participant in the beginning of

their enrollment and administer the same post-test survey questionnaire at the end of the project. (See Appendix 5) The following is a summary of our findings.

Pre and Post-test Aggregate Data for Project Asian Reach Home-Based Outreach Participants:

	Total	Gender	Under 60	60 & over	Language	Lives in Oakland	Lives in Other Cities
Chinese	23	9 male 14 female	1	22	19 Cantonese 4 Mandarin	15	8
Korean	13	2 male 11 female	2	11	13 Korean	8	5

	Lives Alone	Lives with Others	Receives IHSS	Months in Project	Referred to MH services	Isolation (Question 14 : improved score)	Happiness (Question 15 : improved score)
Chinese	8	15	7	3 to 10 months; 2 to 19 visits	3	18 (out of 23)	19 (out of 23)
Korean	8	5	6	3 to 10 months; 7 to 16 visits	2	8 (out of 12; one passed away before Post-test)	7 (out of 12; one passed away before Post-test))

Participants of our home-based outreach were enrolled in our program from 3 to 10 months. There were 23 Chinese participants who each received between 2 to 19 outreach visits from our team. There were 13 Korean participants who each received between 7 to 16 outreach visits from our team.

Overall we found our program made a positive impact in reducing isolation and increasing emotional well-being in a majority of both Chinese and Korean participants. 18 out of 23 Chinese participants reported an improved score for Question 14 on their Post-test compared to their Pre-test, indicating reduction of social isolation after our interventions. 8 out of 12 Korean participants also reported an improved score for Question 14.

Question 14. On a scale of 1 to 10 where 1= Socially Isolated and 10= Socially Connected, how would you rate yourself at this time?

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

Socially

Isolated

Socially

Connected

Similarly encouraging, 19 out of 23 Chinese participants reported an improved score on their feelings of happiness for Question 15 on their Post-test compared to their Pre-test. 7 out of 12 Korean participants reported an improved score for Question 15.

Question 15. On a scale of 1 to 10 where 1=Sad, 10=Happy, what number would best represent how you feel currently?

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

Sad

Happy

PROGRAM STRATEGIES

7. Describe the strategies, methods of implementation and timeframe.

Please refer to **Sections 2 and 3** for our program strategies.

Implementation of our 18-month Innovation Project Asian Reach was divided into four phases with the following timeframe:

-Project Start-up: 4 months (May to September 2014)
During the start-up phase, we recruited our project staff which included a project director (0.1FTE), a clinical supervisor (0.1FTE) from within ACMHS, three bilingual clinicians (0.5FTE each) and 6 peer mentors serving 1 to two days per week. Originally we had anticipated this phase to be completed in 3 months but the recruitment process turned out to take longer with interviewing multiple applicants and human resources procedures.

After recruitment was completed, clinical staff helped with the development of bilingual program flyers (Appendix 1), peer mentors training curriculum (Appendix 2), and Pre-test/Post-test Questionnaire (Appendix 5) as an evaluation tool. We conducted a field test with several community members from the Chinese and Korean communities

before finalizing our Questionnaire. Our project director developed the Initial Screening Tool (Appendix 6) and various project forms to ensure a smooth work flow, documentation that is HIPAA compliant, and essential data collection (See Appendices 3, 7, 8, 9). Training of peer mentors were completed at the end of the Start-up phase. Peer mentors attended two half-day training provided by our clinicians using our training curriculum and role play. They also attended a Mental Health First Aid Training offered by Alameda County Behavioral Health Care Services as the second part of their training.

-Project Publicity: 7 months (September 2014 to March 2015)

Our project publicity strategies included putting advertisements in Chinese and Korean local newspapers and distributing bilingual flyers at key community locations where a large number of Chinese and Korean immigrants visit, such as public library, churches, senior centers, senior housing and health clinics. Electronic copies of program flyers were sent to a vast network of providers, consumer and family member organizations. We originally anticipated doing three months of publicity only. However, by the end of three months, we still did not have the targeted number of participants enrolled in our home-based program so we decided to extend the publicity phase for another four months. (Please refer to **Section 5** Outreach for more details)

-Project Launch: 12 months (September 2014 to August 2015)

Part of Project Launch phase occurred concurrently with Publicity Phase. As we began to publicize our program, calls and referrals came in and our teams of clinician-peer mentors began to actively engage participants. As we continued ongoing outreach, more participants were recruited to receive regularly scheduled home-based visits by our clinicians and peer mentors. (Please refer to **Section 5** Engagement, Interventions, Referral and Connecting for greater details).

-Project Evaluation: 3 months (September to November 2015)

We decided to end our place-based outreach in July 2015 and home-based outreach at the end of August 2015 to leave two and a half months for project evaluation. During these final months of our project, we focused on data analysis of our Pre-test/Post-test results, organized a field test focus group consisting of consumers, family members and providers, as well as the writing of final program design and final online report.

TARGET SUBPOPULATION

8. Our project originally targeted a rather wide scope of six groups of subpopulations among Asians who are isolated and living in any city within Alameda County:

-monolingual Cantonese-speaking adults
-monolingual Cantonese-speaking older adults
-monolingual Mandarin-speaking adults
-monolingual Mandarin-speaking older adults
-monolingual Korean-speaking adults
-monolingual Korean-speaking older adults

	Total	Gender	Under 60	60 & over	Language	Lives in Oakland	Lives in Other Cities
Chinese	23	9 male 14 female	1	22	19 Cantonese 4 Mandarin	15	8
Korean	13	2 male 11 female	2	11	13 Korean	8	5

Our year-long outreach and engagement efforts yielded the above outcomes. The majority of Chinese participants reached and retained were Cantonese-speaking older adult women who live in Oakland. Similarly, the majority of Korean-speaking participants reached and retained were older adult women living in Oakland. This finding is consistent with health and census data that women, on average, live longer than men. It is also consistent with Alameda County statistics that a slight majority of Alameda County's older adult population resides in north county (52.6%). These findings and our learning through our project implementation have helped us to refine our program design and strategies which we will discuss in the **Program Replication** Section later on.

9. Our project recruited and trained BHCS consumers and family members as our peer mentors to launch home-based and place-based outreach. Throughout the project, we received referrals from and collaborated with BHCS providers such as GART clinicians and ACMHS Asian ACCESS staff. Our project staff also collaborated with BHCS contracted prevention and early intervention services providers at ACMHS to co-facilitate Art and Wellness Groups at three senior housing facilities.

A field test focus group was held on October 1, 2015 at ACMHS with 17 guests and 7 project staff in attendance. Among the 17 guests, there were 9 consumers from ACMHS Community Advisory Board and POCC Asian American Committee, 3 family members

from NAMI South County Chinese Chapter, and 4 providers from GART and Oakland senior housing facilities, 2 providers/family members from ACBHCS Consumer Empowerment and FERC. The group had a robust discussion and provided valuable feedback and suggestions to improve our final program design which have been incorporated into the **Program Replication** Section.

10. How are the strategies culturally responsive to the target population?

Throughout each phase of the project, we employed culturally responsive strategies to outreach, engage and provide interventions to monolingual Cantonese, Mandarin and Korean-speaking isolated adults and older adults.

As described in detail in **Section 5**, our outreach strategy utilized local Chinese and Korean print media and targeted places frequently visited by our target populations. During the engagement and intervention phases, we deployed bilingual, bicultural clinicians and peer mentors who could communicate with participants in their native languages and easily build a trusting relationship over time. Our teams tried to discover cultural hobbies and historical discussions of interest to participants to engage them. The following are a few examples of how our culturally responsive interventions which helped to reduce isolation and improved emotional well-being of the participants.

- A Chinese elderly man in his 80's was a journalist before moving to this country. He used to practice Chinese calligraphy. Due to aging and isolation he no longer did. The peer mentors encouraged him to resume this art and hobby by buying the necessary supplies of brush, paper and ink and brought them to his home. They asked him to demonstrate. As a result, he enjoyed this hobby once again and felt empowered. He even volunteered at our Lunar New Year Celebration and City of Oakland Healthy Aging Fair ACMHS resource table to demonstrate Chinese calligraphy.

- A Chinese elderly couple indicated they used to enjoy playing Mar-Jong game with friends but due to health-related limited physical mobility, they stopped and remained isolated at home. It takes four people to play this very popular traditional Chinese game. During the two peer mentors' home visit, the couple took out their game and started to teach the peer mentors to play Mar-Jong, with the agreement of no gambling. (Oftentimes Mar-Jong involves gambling: win/lose money). The couple was able to enjoy this intellectually stimulating table game again as well as social conversations around the table.

- A Chinese elderly couple used to enjoy singing Cantonese Opera. They brought many VCD (video discs) from Hong Kong when they immigrated to the United States. However, their VCD player broke and because of language and transportation barriers, they had not been able to find a replacement. Our peer mentors discovered their desire and need and were able to assist them in purchasing a new VCD player from Oakland Chinatown that was compatible with the discs they had. They were overjoyed to be able to enjoy their favorite hobby again.

- A Cantonese widower in his 90's was depressed and isolated after losing his wife of 65 years rather suddenly. He lives alone and all his adult children live out of state. When our clinician-peer mentor team made their initial home visit, he indicated he desired social connection but did not wish to have ongoing home visits. He was physically healthy and mobile. He wanted help to regain the motivation to go out and socialize with others again. Our only one male peer mentor began to engage him by taking public transportation with him to go out and have Dim Sum in Oakland Chinatown. During other visits, our peer mentor accompanied him to visit several senior centers in Oakland Chinatown that provide social recreational activities Monday through Friday. There was such a positive bonding that when our peer mentor resigned early to move out of state to attend graduate school of social work, this elderly man insisted on treating him and our clinicians to a farewell dinner to celebrate this young man's new venture and to say goodbye.

- A Korean elderly woman grew up in Korea. During her childhood years, she experienced some degree of hearing loss. After immigrating to the United States, she was able to have corrective surgery to restore her hearing. As our team of bilingual Korean clinician-peer mentor visited her and discovered her history through engaging conversations, they also found out that due to her childhood hearing loss, she missed the opportunity to learn to read the Korean language well as a child. Now with her hearing fully restored, she has a strong desire to learn to read and write her own native language. During our peer mentor's subsequent visits, she enjoyed being coached to read cultural books in Korean.

EFFECTIVENESS OF STRATEGIES

11. How do you know these strategies are effective in achieving the goal of reducing isolation for the target population?

The above examples and participants' positive verbal feedback, coupled with our Pre-test/Post-test Questionnaire results described in **Section 6** have shown our strategies to be effective in achieving the goal of reducing isolation for the target populations.

However, we were not quite effective in reaching those who were seriously mentally ill. A case in point: A Korean family saw our newspaper advertisement and called to meet with our clinician. An elderly mother and a young adult son in that family were struggling with serious mental illness that severely impacted their daily functioning and causing much stress for other family members. When our clinician offered to make an outreach home visit to meet the seriously mentally ill family members, two other family members who were caregivers declined the offer. We then attempted to offer an office visit for the young adult son to provide non-stigmatizing assistance such as helping him apply for Medi-Cal as he did not have any health insurance. The adult son was not motivated to come. Our clinician reassured the family that they could call her when ready. A few months later, she did get a call back from the adult sibling reaching out for help because her brother had now been incarcerated and she wanted help to advocate for him to be transferred to a psychiatric facility. Information, resources and support were provided to this family member.

12. Describe the process for arriving at the Program Design supported by evidence-based or community defined best practices.

Our process of arriving at the Program Design began with brainstorming among a small group of Chinese and Korean clinicians at ACMHS during the phase of writing our proposal for Innovation Grant Round 3. With their years of professional experiences in providing culturally responsive services to our target populations, coupled with some research and literature search on effective interventions for the isolated with mentally illness, we came up with our program strategies to test them out during the implementation of our Innovation Project. We collected and analyzed data from our pre/post-test questionnaire toward the end of the project to evaluate the effectiveness of our strategies. We also held a field test focus group with consumers, family members and providers familiar with our target populations to further gather input to refine our program design to come up with a community defined best practice.

13. Provide quantitative and qualitative data that show the effectiveness of the strategies. Include assessment tools and measures of effectiveness and data sources used.

Please refer to **Section 6** for quantitative data and **Section 10** for qualitative data that show the effectiveness of our strategies. Please see **Appendices 5 and 6** for our Pre/Post-test Questionnaire and Initial Screening Tool.

PROGRAM REPLICATION

14. What are your recommendations for program replication, including essential elements for successful replication?

To answer this question, we first want to share what we have learned from some of the challenges we encountered during the implementation of our Innovation Project. Based on our learning, we have made some revisions to our program design for successful replication.

Some of the challenges we encountered which we had not anticipated were:

- Turnover of peer mentor volunteers (3 Koreans)
- Difficulty in coordinating home visits schedules among 2 team members and participants
- Extended travel time required to visit those who live far from our Oakland office (e.g. Fremont, Union City, Newark)

Participant Demographics --- Even though our original scope of work targeted both isolated adults and older adults, at the end of the project, our data showed the majority of those we had reached were older adults who lived in the city of Oakland. Therefore in our revised program design described below, we have narrowed our scope with both the target age group and geographic area to give the project a sharper focus and greater collaboration with local entities. We have chosen the city of Oakland because it is where our main office is located. Others who want to replicate the program can choose another city (or cities) close to their agency and where there is a high concentration of Chinese and Korean senior population.

In our modified program design, we have reduced the number of peer mentors from 6 to 2 but increased the hours of each so that they become agency employees rather than volunteers with a small stipend. This will solve the challenges of high turnover as well as minimize coordination of schedules among multiple team members.

Modified PROGRAM DESIGN

Target Populations: Cantonese, Mandarin and Korean-speaking seniors with mental health challenges

Geographic Area: City of Oakland

Localized Focused Outreach: Rather than advertising in Bay Area Chinese and Korean newspapers, one of the recommendations from our field test focus group was to put bilingual advertisements on bus benches or bus shelters near senior housing buildings with large number of Chinese and Korean residents in Oakland.

15. Staffing requirements:

Job Title	% FTE	Responsibilities	Qualifications
Project Director	20%	Program Planning, Staff Recruitment, Program Evaluation	Non-licensed master's level experienced in program administration
Clinical Supervisor	20%	Staff Supervision & Staff Evaluation	Licensed Clinician
Mental Health Clinician (Chinese)	100%	Provides screening, assessment, therapy, crisis intervention and referral to isolated seniors with mental health challenges; Services may be provided at home, at a senior housing facility or in our office per client's desire; Provides psychoeducation workshops to senior audience at senior centers and senior housing facilities; Teamwork with Peer Navigator to perform joint	Bilingual Cantonese & Mandarin-speaking licensed or license-track clinician experienced in geriatric mental health

		outreach and home visits	
Mental Health Clinician (Korean)	80%	Provides screening, assessment, therapy, crisis intervention and referral to isolated seniors with mental health challenges; Services may be provided at home, at a senior housing facility or in our office per client's desire; Provides psychoeducation workshops to senior audience at senior centers and senior housing facilities; Teamwork with Peer Navigator to perform joint outreach and home visits	Bilingual Korean-speaking licensed or license-track clinician experienced in geriatric mental health
Peer Navigator (Chinese)	60%	Performs outreach, translation and case management services at targeted senior housing facilities; Visits individual isolated residents who are open to receive visitation	Bilingual Cantonese & Mandarin-speaking peer or family member with lived experience
Peer Navigator (Korean)	50%	Performs outreach, translation and case management services at targeted senior housing facilities; Visits individual isolated residents who are open to receive	Bilingual Korean-speaking peer or family member with lived experience

			visitation
Administrative Assistant	Hourly as needed	Data entry of Client data and pre/post test data	High School Graduate or AA degree with data entry experience
Contractors	Hourly as needed	Co-facilitate Art & Wellness Groups at senior housing facilities with our peer navigator staff	Teaching artist and music therapist experienced with running activities groups for seniors with mental health challenges; Bilingual in Chinese or Korean preferred

16. Our **Main Collaborators** will be independent living senior housing facilities in Oakland as our targeted "place-based outreach" sites rather than launching place-based outreach in public locations such as library and grocery stores. The goal is to target two to three senior housing facilities that have large populations of Chinese and Korean residents and which do not offer many social recreational activities on-site, or which do not have any bilingual social service coordinators on-site.

As pointed out by our field test focus group participants, home-based outreach maybe too threatening to some seniors who either do not trust strangers to visit or do not feel their home is presentable to guests. Offering translation and case management assistance in the lobby of their senior housing facility would be a welcome service that meet the seniors' felt need and help to build trust. As mentioned above in Staffing Section, we will train our two peer mentors on providing case management assistance to seniors. Peer mentors will be the ones performing this type of outreach at targeted senior housing facilities twice a month. Their consistent and frequent presence will help build trust with the residents and generate referrals to needed mental health services that our clinicians could follow up.

Other collaborators will include a network of mental health services, adult day health centers and social recreational services such as Asian ACCESS, GART (Geriatric

Assessment Response Team), Hong Fook Center, CEI (Center for Elders' Independence), Hong Lok Center, Lincoln Park Senior Center, Korean American Senior Center to refer isolated seniors as needed.

17. Resources, facilities, infrastructure needed for support:

- Technology and equipment needs: To ensure HIPAA compliance, an electronic health record system is highly recommended. If this is not feasible, client's paper charts stored in doubled locked facility is recommended (e.g. a locked file cabinet in a locked chart room).

- Systems and service needs (e.g. billing, interpreter): Our program design includes employment of bilingual, bicultural clinicians and peer navigators so there is no need for interpreter. This program design assumes funding from Mental Health Services Act Prevention and Early Intervention so there is no need for Medi-Cal or MediCare billing. However, with licensed or licensed-track clinicians providing clinical services, it is worthwhile to explore the possibility of billing Medi-Cal and MediCare. The clinicians need to go through an application process to become Medi-Cal and MediCare providers who are eligible to bill. In addition, with the proposed state legislation on certification of and billing by trained peer navigators, there is a possibility of peer navigators billing Medi-Cal for services in the future.

- Budget requirements for a 12-month Period:

Budget Item	Budget	FTE
Personnel		
Project Director	13,000	20%
Clinical Supervisor	13,000	20%
Mental Health Clinician I	63,000	100%
Mental Health Clinician II	50,400	80%
Peer Navigator I	21,000	60%
Peer Navigator II	17,500	50%
Administrative Assistant	6,400	20%
Fringe Benefits	46,075	@25%
Personnel Total	230,375	
Non-Personnel		
Contractors (Teaching artist and music therapist)	7,680	Hourly @ $40 per hour

Program Publicity	3,200	
Staff Travel	1,650	
Program Expenses	1,560	
Program Supplies	1,750	
Office Supplies	1,280	
Rent & Utilities	6,566	
Insurance	650	
Administrative Overhead	38,206	@ 15%
Non-Personnel Total	62,542	
Total Budget	292,917	

One-time cost: None (Our initial training of peer navigators were conducted by our clinical staff and certified trainers of Mental Health First Aid at no cost to participants)

Other resources required for infrastructure support:

During the implementation of our Innovation Project, we discovered the lack of **transportation** is often a barrier for isolated individuals to gain access to community activities. For monolingual Chinese and Korean seniors, there is a double barrier in accessing transportation such as Paratransit system due to language barrier. In this final modified program design, we want to recommend active exploration of a network of accessible transportation for seniors in the city of Oakland such as the Taxi Scrip program which lets eligible residents purchase up to 12 books of taxi coupons worth $28 for $3 each every year. For $36, eligible seniors can get $336 worth of taxi rides with three currently contracted services: Friendly Cab, Metro Yellow Cab, and Veterans Cab. It would be helpful to proactively match seniors with drivers who speak their language (Cantonese, Mandarin or Korean) to enable more isolated seniors to attend social events.

APPENDICES

1. **Project Asian Reach Program Flyers (English, Chinese, Korean)**
2. **Peer Mentors' Training Manual**
3. **Home-based Referral Log**
4. **Consent to Outreach Visits (English, Chinese, Korean)**
5. **Pre-Test/Post-Test Questionnaire**
6. **Initial Screening Tool**
7. **Home-Based Visitation Log**
8. **Home-Based Client Discharge Log**
9. **Place-Based Outreach Log**
10. **Lunar New Year Celebration Flyer**
11. **Art and Wellness Group Flyer**
12. **Community Resources**

Hand-in-Hand,
Heart-to-Heart!

Do you or a loved one suffer(s) from depression, social isolation or other mental health/emotional challenges?

Project Asian Reach may be able to help!

Our Social Workers and Peer Mentors can visit you at home to share helpful resources.

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Training for Innovation Grant Project Asian Reach Peer Mentors: Part I

1. Confidentiality of clients information and HIPAA

Confidentiality is an ethical and legal requirement placed on the mental health practitioners and other professionals that restricts the volunteering of information obtained in a therapeutic relationship. Confidentiality is an essential part of any clinical relationship. All aspects of client information we obtained during the clients contact are confidential. Keeping the clients information confidential facilitates trust between the client and the people who providing the care. But there are some exceptions to the confidentiality.

Congress enacted the Health Insurance Portability and Accountability Act in 1996, which went into effect in April 2004. HIPAA only applies to health care providers who engage in certain covered transactions on behalf of patients with third party payers (insurance companies, HMOs, etc) AND who engage in those transactions electronically or using computer-based technology.

When/if confidentiality should be and can be broken

1) Mandated Exceptions to Confidentiality:
   A. Child abuse: (0 to under 18 year old)
      Must be reported if mandated reporters have knowledge or reasonable suspicion of physical abuse, neglect and sexual abuse.

   Dependent Adult and/or Elder Abuse: (Dependent Adult: 18-64 years old, Elder 65 or order)
      Dependent Adult : any person who residing in the state of California, who has physical, mental or financial limitations which restrict his or her ability to carry out normal activities of daily living, ability to protect his or her own rights, and which threaten the individual's capacity to live an independent life.

      Must be reported if mandated reporters have knowledge or reasonable suspicion of physical abuse, abandonment, isolation, neglect, financial abuse, or abduction of an elder or dependent adult.
   B. Tarasoff (Duty to Warn)
      A therapist has a duty to protect an intended victim from threatened harm. Warn the intended victim and the police

2.) Permitted Exceptions to Confidentiality:

Evidence code Section 1024 allows an exception to confidentiality.

A. Client is suicidal and the disclosure is made to prevent the threatened harm to s elf
   It is not mandated responsibility for mental health practitioners to report but they have ethical responsibility to keep clients to harm himself or her.
B. Consult with Other Health care Providers
C. Release authorizations.

Mandated Reporters in California

- Social workers
- Teachers, principals, and other school personnel
- Physicians, nurses, and other health-care workers
- Counselors, therapists, and other mental health professionals
- Child care providers
- Medical examiners or coroners
- Law enforcement officers etc.

Peer mentors are not mandated reporters according to CA Law

Watch for:

- Using a client's or family member's name or identities where someone can hear and draw conclusions
- Talking with other people about the clients
- Giving information that would let people recognize clients

The Bottom line

- Think confidentiality and privacy are essential part of relationship with clients.
- Share only what you need to share
- Always have an authorization before sharing someone's confidential information

2. Active Communication Skills

Communication is the basic essential element of all that we do; it is at the heart of our relationships with clients, co-workers, supervisors, loved ones. It is a skill we use constantly! There are many ways we can communicate better with our clients.

The Active Listening Skills

Listening is the key for effective communication with clients.

- **Repeating/rephrasing**
  Sometimes, simply repeating back what a person has said is a most helpful response... It means you have accurately heard the person. It is a very supportive response.

  What I hear you saying---
  What I seem to be haring

- **Paraphrasing:**
  The listener makes a major restatement of what the individual said –it is an attempt to interpret what the listener has heard. You may or may not be right – but this type of response allows an individual to clarify what they meant and improves understanding between both the listener and listenee

- **Summarizing:**
   Organizing and summing up that which has gone before.
  "Have I got this straight?"
  "You've said that---"
  "During the past hour you and I have discussed---"

- **Validation:**
  Validation is one way that we communicate acceptance of others. It is the recognition and acceptance of another person's thoughts, feelings, and behaviors as understandable. It doesn't mean agreeing or approving. When your best friend or a family member makes a decision that you really don't think is wise, validation is a way of supporting them and strengthening the relationship while maintaining a different opinion.

'"I" statement:

An important skill for communication is the use of "I" statement. This tool promotes understanding through taking personal responsibility for one's feelings and being objective and clear.

These statements are a way of expressing how you feel about a situation without placing blame or drawing a defensive or argumentative response from the other person.

To begin using "I" statements, follow a basic format of three parts:

1. When, (provide nonjudgmental description of behavior)
2. I feel, (name your feeling)
3. Because,(give the effect the behavior has on you or others)

Or you may want to state your feelings first and follow this format:

1. I feel (name our feeling)
2. When (provide nonjudgmental description of behavior)
3. Because (give the effect the behavior has on you or others)

Either format will work as a means of effective communication. Using "I" Statements may feel awkward at first, but with a little practice, it will become a regular part of your communication style.

Example of "you" statement and "I" statement

- Your music is too loud and driving me crazy
- I feel anxious when the music seems too loud to me because I can't hear myself think.

- You don't think of anyone but yourself
- When you didn't pay your half of the bills this month, I felt angry and worried because I thought we might lose the apartment.
- I feel angry because you never do your chores
- I feel angry when your chores are not completed because I value having a neat and clean house.

After saying "I feel" be sure to use a feeling word.

- Beware of disguised "you" statement (I feel that you----)
- Beware of using "like" or "that after the "I feel" ---it indicates a thought, not a feeling.
- Remember to use these statements to reflect positive feelings as well, not just the negative.

One of the challenges of using "I" statements is that people may be unclear of what a feeling statement is. Remember, that states of being, like being hungry or tired, are not actually feelings, words like angry, anxious, scared, irritated, happy, joyful etc, are all feelings.

Roadblocks to Effective Communication

- Ordering, directing or commanding:
  "Stop feeling sorry for yourself----"

- Warning or threatening:
  "You'll never make friends if---" "You'd better stop worrying so much for---"
- Moralizing, preaching or telling clients what they should do:

"Life is not a bowl of cherries---" "You shouldn't feel that way---"

- Advising, giving solutions:
  "What I would do is----" "Why don't you----"
- Persuading with logic, arguing or lecturing:
  "Here is why you are wrong---" "The facts are----"
- Judging, criticizing, blaming:
  "You are not thinking maturely---" "You are just lazy---"
- Praising, agreeing:
  "Well, I think you're doing a great job"
- Name-calling, ridiculing:
  "Cry baby," "That's stupid to worry about one low test grade".
- Analyzing, Diagnosing:
  "What's wrong with you is---" "You're just tired, ---"
- Reassuring, sympathizing:
  "Don't worry,---" "You'll feel better, ---"
- Probing and questioning:
  "Why---?" "Who---?" "What did you---"?
- Diverting, Sarcasm, withdrawal,
  "Let's talk about pleasant things---" "Why don't you try running the world."
  (Thomas Gordon, 1970)

3. **Supportive Relationship Building**

Peer mentors are to visit clients' homes during the course of Innovation Project.

Through the clients contact, peer mentors are to develop supportive relationship with clients. Supportive relationship building is essential between a client and the peer mentors. Through this supportive and trusting relationship, peer mentors can encourage, motivate, and instill hope to improve client's mental functioning and gradual recovery. Peer mentors provide social contact to the clients who are isolated and withdrawn due to their mental illnesses. Through this type of social contact, clients can aware of resources available to them and the help is within their reach. Peer mentors can be a role model to clients who are suffering from mental illnesses.

Carl Rogers's person-centered approach may be helpful for the relationship building with clients.

Person-centered approach believes that people are responsible and possess the power to direct their own lives. Rogers has deep faith in the tendency of human to develop in a constructive way if an atmosphere of trust and respect is established. The atmosphere of trust and respect is established if the therapist demonstrates **unconditional positive regard, empathy, and genuineness**.

Among the three characteristics above, I believe that empathy is an attitude which mental health practitioners strive to cultivate.

In counseling, the therapist senses the feelings and personal meanings that the client is experiencing and communicates this understanding to the client. This is the way a therapist shows his/her empathy toward his/her client. In a layman's language, empathy is an attitude of standing in the others' shoes, of viewing the world through the other person's eyes.

Over the years, research evidence keep piling up and it point strongly to the conclusion that a high degree of empathy in a relationship is possibly the most potent and certainly one of the most potent factors in bringing about change and learning.

There are a number of ways we can express empathy to another person.

For example:

- Reflecting a person's expressed feelings back to them.
- Paraphrasing what a person has said to you to demonstrate an understanding.

There is another word called sympathy its meaning is very similar to empathy.

Often empathy and sympathy can be confused, but understanding the difference between the two can make us more effective communicators.

There is a difference between empathy and sympathy, but understanding the difference between the two can make us more effective communicators.

The sympathy is to make it known that you are aware of another's distress and that you have compassion for them. Empathy on the other hand, takes things a step further by not only expressing compassion but also showing a deeper into the other person's experience.

<u>Examples of sympathy versus empathy are the following:</u>

<u>Sympathy</u>	<u>Empathy</u>
I am so sorry about your loss.	I can understand your grief.
How awful! Poor you!	I understand this has been a great loss for you.
Let me do that for you.	Can I help you with that?

I feel so sad for you.   I feel and understand your pain.

4. Healthy Boundaries:

Mental Health practitioners are required to maintain professional boundaries with their clients. Healthy boundaries are integral to an individual's well-being. Good boundaries create safety and containment, a sense of security and comfort. When working in the mental health field, these issues become even more important as mental health practitioners work with the clients who are vulnerable due to their mental illnesses.

Pat Deegan, PhD., has outlined some factors to review in order to determine a healthy and appropriate boundary.

Core factors of determining Boundaries:

- Ethics:
  An Ethics is a set of rules and standards of behavior. Professional organizations or guilds have developed separate standards for themselves.
  For example, MFT's Ph.D.'s, LCSW, Feminist therapist etc...
- Role expectations:
  What is expected of me in my job? A key question to ask yourself "Is this a part of my job description?
- Personal preferences:
  Each of us has dislikes that we draw regarding what's ok and not ok. Not all boundaries are created equal! The only exception to this is ETHICS! And one in particular; DO NOT HAVE SEX WITH YOUR CLIENTS. People have definite preferences in what they are comfortable or not comfortable with (Hugging is a good example).
- Client's expressed wishes:
  Sometimes the personal preference that set the boundary is the one the client makes.

  Boundaries take two people!

  The person with the stricter boundaries is prioritized. (huggers vs. non-huggers).

  Ask!

Self-Disclosure:

Self-disclosure is a very personal decision – how much to say, who to say it to and when to say it are all part of the complex process of determining the level of sharing in any given situation. As we, mental health practitioners are think through before we

share our own personal information. **Think about whether this disclosure would be beneficial to the clients and comfortable doing so.**

Low level of Disclosure:

- Facts
- Not too personal
- Easy to share with anyone.
E.g. I enjoy reading

Medium level of Disclosure

- Unique biographical facts
- Opinions
- Sometimes risky to share
E.g. I have diabetes

High level of Disclosure:

- Very personal
- Risky to share
- Used only if you trust the other person
- Used only if the other person is willing to listen
E.g. I was abused as a child.

Signs of Healthy boundaries:

- Appropriate trust
- Maintaining personal values despite what others want
- Noticing when someone invades your boundaries
- Saying "No" to gifts, money, touch you don't want
- Asking a person before touching them.
- Respect for others –not taking advantage of someone's generosity.
- Not enter into dual relationships or commitments that conflict with the interests of those they serve.
- Never engage in sexual or intimate activities with clients they work with.
- Will not use illegal substances under any circumstances.

Signs of Unhealthy Boundaries

- Trusting no one –trusting anyone. Black and white thinking
- Telling all
- Talking at an intimate level on the first meeting
- Going against personal values or rights to please others.
- Not noticing when someone else displays inappropriate boundaries
- Not noticing when someone invades your boundaries.

- Accepting gifts, money, touch, sex that you don't want
- Touching a person without asking
- Letting others direct your life
- Believing others can anticipate your needs.
  - Expecting others to fill your needs automatically
  - Falling apart so someone will take care of you

Setting Limits

The ability to set limits is essential to feeling good about yourself. Peer mentors may not know or used to put themselves first or to say "no." Learning to say "no" is a difficult challenge; it is a relief to be able to stop doing what you don't want to. By setting limits, you protect yourself and give yourself freedom at the same time. As you become more at ease with setting limits a simple. "no, I don't want to", no thanks," or "no, I would rather not" will become easier.

Setting limits with "Gentle Refusal"

Have you ever been in a situation where you have been asked to do something you really didn't want to do, but didn't know how to say "no"? Can you think of recent times where you wanted to help out, but not to the extent that you did become involved?

If during a conversation, you find that you have to set limits, one effective way is to set limits with gentle refusal. This skill provides you with a way to say "no" as gently and caringly as possible, while inviting the other person to continue to explore with you on a more constructive level.

Do not let people place conditions on your helping them. You will find it helpful to use gentle refusal when.

- A person makes unrealistic demands on you
- A person demands advice
- A person asks personal questions and you feel uncomfortable
- A person is verbally abusive
- You just want to end the conversation.

Duties and Responsibilities of Peer Mentors

1. Complete Peer Mentor training and orientation to Project activities
2. Partners with Project Clinician to develop bilingual outreach material.
3. Performs community outreach to advertise Project at key community locations in Oakland
4. Makes initial joint home visit with Project clinician
5. Pairs up with another Peer Mentor to make subsequent home visits to Project

enrollees.

6. Performs in-home socialization and wellness activities with Project enrollees who are older and/or isolated adults with diagnosed or undiagnosed mental health challenges.
7. Communicates with Project Clinician re; mental health needs or crisis of project enrollees.
8. Participates in Project team meetings at least twice a month.
9. Assists Project staff in conducting focus groups with community members...
10. Attends Alameda County-sponsored Innovation Round 3 final Learning Conference.

Additional roles and responsibilities

- Model recovery, resilience, wellness, and hope in your peer mentor role
- Develop a supportive relationship with the clients
- Explain to clients scope and availability of services
- Adhere to established/agency policies and procedures

5. Taking Care of Yourself

Self-care is an essential part to survival for the mental health practitioners as well as others. Yet it is something that is often neglected due to various reasons. It is best for mental health practitioners to take time to take care of themselves first and then we can take care of others effectively.

One way of taking care of self is **to manage your stress.**

Management of Stress:

Stress is a term that people often use to describe a feeling of pressure, strain, or tension. People often say that they are "under stress' or feel "stressed out" when they are dealing with challenging situations or events.

Everyone encounters stressful situations. Sometimes stress comes from something positive (such as a new job. New apartment, or new relationship) and sometimes it comes from something negative (such as being stuck in the traffic, having an argument with someone or being the victim of crime).

Nobody has a stress-free life and probably nobody would want one. Stress is a natural part of life. In fact, in order to pursue important personal goals, you must be willing to take on new challenges, which can be stressful. Being able to cope effectively with stressful situations can minimize the effects of stress on your body enabling you to continue pursuing your goals and enjoying life.

What makes you feel under stress?

Different people find different things stressful. For example, some people enjoy the hustle and bustle of a big city while others don't and find it stressful. Some people enjoy going to a party and meeting new people, while others find that stressful. Knowing what you personally find stressful will help you cope better.

Two main types of stress exist:

- Life events and
- Daily hassle

Life events refer to experiences such as moving, getting married, the death of a loved one, or having a baby. Some life events are more stressful than others. For example, getting a divorce is usually more stressful than changing jobs.

What are the signs that you are under stress?

Stress affects people physically and emotionally. It also affects their thinking, mood, and behavior. Some people show only physical signs of stress such as muscular tension, headaches or sleep problems. Others have trouble concentrating or become irritable, anxious, or depressed. Still others may pace or bite their rails. Each person's response to stress is individual and different.

Being aware of your own signs of stress can help because once you realize that you're under stress, you can start to do something about it.

Signs of Stress:

- Headache
- Sweating
- Increased heart rate
- Back pain
- Change in appetite
- Difficulty falling sleep
- Increased need for sleep
- Trembling or shaking
- Digestion problems
- Stomach aches
- Dry mouth
- Problems concentrating
- Anger over relatively minor things
- Irritability
- Anxiety
- Feeling restless or "keyed up"
- Tearfulness

- Forgetfulness
- Being prone to accidents
- Using alcohol or drugs(or wanting to)

How can you cope effectively with stress?

Coping effectively with stress is a key to living a successful and rewarding life and being able to pursue your personal goals.   Some examples of strategies for coping with stress include the following:

- Talk to someone about the stress you are experiencing
- Use a positive self-talk
- Maintain your sense of humor
- Participate in a religious or spiritual activity
- Engage in regular exercise
- Write in a journal
- Make or listen to music
- Create art or go to see art
- Play games or develop a hobby.
- Use relaxation techniques
    - Relaxed breathing
    - Imagining a peaceful scene
    - Muscle relaxation

Training for Innovation Grant Project Asian Reach Peer Mentors: Part 2

6. Wellness and Recovery approach for mental illnesses.

A recovery approach to mental disorder or substance dependence emphasizes and supports a person's potential for recovery. Recovery is generally seen in this approach as a personal journey rather than a set outcome and one that may involve developing hope a secure base and sense of self supportive relationships, empowerment, social inclusion, coping skills, and meaning. People with mental disorders do recover. Millions of people with psychiatric diagnoses are living full and satisfying lives. There is no one-size fits-all path to recovery. What works for one person may not work for another.

Originating from the 12-step- Program of Alcoholics Anonymous and the civil rights movement, the use of the concept in mental health emerged as deinstitutionalization resulted in more individuals living in the community. It gained impetus as a social movement due to a perceived failure by services or wider society to adequately support social inclusion, and by studies demonstrating that many people do recover. A recovery

approach has now been explicitly adopted as the guiding principle of the mental health or substance dependency policies of a number of countries and states. Many studies have shown that unexpectedly high rates of complete or partial recovery took place.

Elements of Recovery

It has been emphasized that each individual's journey to recovery is a deeply personal process, as well as being related to an individual's community and society. A number of features or signs of recovery have been proposed as often core elements.

- **Hope**: finding and nurturing hope has been described as a key to recovery. It is said to include not just optimism but a sustainable belief in oneself and a willingness to persevere through uncertainty and setbacks.
- **Secure Base**: Appropriate housing, a sufficient income, freedom from violence, and adequate access to health care has also been proposed.
- **Self-identity**: Develop the positive self-identity and self-worth including current and future self-image
- **Supportive relationships**: A common aspect of recovery is said to be the presence of others who believe in the person's potential to recovery, and who stand by them.
- **Empowerment and inclusion:**
  Empowerment and self-determination are said to be important to recovery, including having self-control. This can mean developing the confidence for independent assertive decision making and help-seeking. Achieving social inclusion may require support and may require challenging stigma and prejudice about mental distress/disorder/difference.

- **Coping strategies:**
  The development of personal coping strategies (including self-management or self-help) is said to be an important element. Developing coping and problem solving skills to manage individual traits and problem issues (which may or may not be seen as symptoms of mental disorder) may require a person becoming their own expert.
- **Meaning in life**, including life purpose and goals in people's lives which is important in their recovery.

Some basic assumptions of a recovery-oriented mental health system are that:

- Individuals living with mental illness [may] need support to lead personally satisfying, hopeful and contributing lives;
- Recovery from mental illness can occur even though symptoms of illness reoccur; recovery is not a linear process but it is unfolding and on-going;
- Recovery assists individuals to reduce symptoms' frequency and duration;

- Recovery assists individuals to deal with losses and consequences associated wi th mental illness;
- Recovery requires recruitment and involvement of people who believe in and assi st individuals to pursue their hopes and goals; and,
- Recovery requires dedicated human and fiscal resources

7. **Assessing Risk and Personal Safety in the field.**

Peer mentors are to involve seeing clients in the community as well as in their homes. Besides getting to know the person and finding out about their needs and mental condition, the peer mentors also pays attention to signs of trouble or concern in the environment.

Types of Risk

- Risk of harm to self, **including suicide:**
  Talking about hopelessness, plan to hurt self, past self-behavior, etc
- **Violence or harmful behavior to others:**
  Intimidating behavior, breaking things, yelling/screaming, etc.

These are the risks that peer mentors may encounter as they meet with clients in their homes.   These risk situations are risks for the clients as well as the peer mentors. If client is extremely agitated or threatening, that poses a risk for the peer mentors as well as family members, then it is in crisis situation.

Some situations are not so straightforward concerning risk. It is important to distinguish life threatening, harmful, situations from situations that really are not that dangerous or life threatening.

Steps to Take

- If it is an emergency – call 911! (e.g. the person is unconscious, danger to others
- If a client is suicidal, peer mentors need to assess client's condition carefully.
  - See the suicide section
- Call your mental health clinician
- Document the steps you took

Every time you make a home visit, take care to notice both the client/family and the environment. If you see a situation that is an emergency, make the call to 911 immediately. If the situation is less urgent, it is often helpful to check in with your mental health clinician, a supervisor or a director for consultation on the best thing to do.

Personal Safety for Yourself (Peer Mentors)

Your job is to care for the safety of your client as well as yourself. Keep yourself safe---you cannot help any client if you yourself are not safe.

Physical:

If you are concerned for your physical safety, leave the home immediately.

- Meeting with the client/family in a place in the home that gives you access to the door (avoid getting backed into a corner)
- Talking in a calm, yet confident tone of voice.

8. **Crisis intervention and Referral to appropriate agency.**

Individuals of all ages, cultures and backgrounds can experience a crisis at some point in their lives, brought on by a variety of situations. Crisis situations are new, unpredictable obstacles that seem insurmountable and are psychologically paralyzing.

What is a crisis?

Crisis is defined as "the presence of an event or situation as beyond the coping mechanisms of an individual." (James & Gilliand, 2004). It is a temporary period of disorganization in the normal psychological state of an individual of family, which

Produces a state of disequilibrium. Crises are constituted y acute circumstances involving grave distress and distraction surrounding affective, behavioral, and cognitive reactions (Brown & Rainer, 2006).

There are a variety of events that may precipitate a crisis, which may be either Developmental or Situational. Situational crises are accidental or unexpected. Examples of situational crises include the loss of loved ones, natural disasters, riots and violent crimes such as rape, accident as well as crises centering on events such as job loss and divorce.

Developmental crises, on the other hand, are those associated with transitions or movement from one developmental stage to another. When there is interference in negotiating expected developmental tasks, a crisis is possible. From this standpoint, many of these crises are "predictable." They may include marriage, the birth of a child, job promotions, living home, adoption, and launching, midlife issues. etc. Here we are go deal with more on situational crisis than the developmental crisis.

The goal of crisis intervention:

- Provide support during the crisis and/or the crisis resolution
- Protect individual health and safety
- Restore the client to a pre-crisis level of functioning.

Crisis Assessment

- Does the client represent a danger to self?
(Assess lethality and safety needs)

- Is the client gravely disabled?
(unable to take care of their most basic needs) a danger to self or others due to

mental disorder

- Is the client a danger to others?
- Gather specific, detailed information
  - Crisis precipitators
  - Impact on client family functioning
  - Ascertain pre-crisis level of functioning
  - Drug/Alcohol use
  - Clients support system/strengths and resources
  - Source of stress
  - Mental health problems and symptoms

The general Crisis Intervention

- Elicit client supports, strengths, coping, resources
  - What has client already tried?
  - How has client coped with past crises?
  - Who can client count on for help and support?
- Help client to gain perspective on self and crisis
  - Predicting what life will be like in two weeks, two months, and two years…
  - Reframing, normalizing

Crisis Communication Techniques:

- Stay calm convey confidence and assurance
  - The client feels s/he is in good hands
  - The client's anxiety and reactivity is reduced
- Reflection and clarification
  - Mental Health worker and client come to a better understanding of the issu es involved.
  - Mental health worker and client can be on the same page
  - Mental health worker and client can more easily collaborate

- Direct questions
  - Uses concrete direct questions to gain more detailed and accurate information.
- Non-verbal communication
  - Clear, easy eye contact
  - Relaxed body and breathing.

DO's and DON'Ts in De-Escalating Crisis Situations

- Do approach clients in a calm non-threatening manner.
- Do be assertive, not aggressive.
- Do allow clients to resolve a situation themselves, if possible,
- Do remove any bystanders from the area.
- Do remove any dangerous articles from the area.
- Do encourage clients to use more appropriate behavior to get what they want.
- Do work with other staff or significant others available as appropriate in defusing a crisis.
- Do give an agitated client time and space to calm down,
- Do negotiate temporary solutions to buy time.
- Do be respectful toward the client.
- Do leave a physical escape route for both yourself and the client.

- Don't get into an argument route for both yourself and the client
- Don't be authoritarian or demanding.
- Don't tell clients you are frightened even if you are.
- Don't argue with clients over the reality of hallucinations or delusions.
- Don't "humor" clients regarding hallucinations or delusions.
- Don't overreact to the situation.
- Don't insist that a client discuss a situation if he or she doesn't want to.
- Don't confront a client under the influence of substances.

Suicide Intervention:

Key words:

"Can't go on"

"Wish I wasn't here"

"Life would be better if I didn't exist"

"I don't know if I will see you next week"

"I'm at the end of my rope"

"This is the last straw"

"All I have left is God"

Giving things away, saying good-bye.

Assessment:

- Use direct questions. Have you thought about killing yourself?
- Ask specific plans, means, intent (e.g. medications for elderly and over-the-co unter medications kids; gun)
- Refer client to psychiatrist
- Observe client's grooming, affect, slowed psychomotor activity flat affect etc.
- Beck Depression Inventory; Suicide Lethality Scale
  (80% of people who attempted suicide are clinically depressed)
- Ask about the use of alcohol and other drugs
- Prior attempts, family history of suicide
- Support system (who's around, extended family, religious support, impact on others.)

Management:

Least intrusive to most intrusive interventions

- No suicide contract (increase sessions, calling between sessions, eliminate mea ns if possible)
- Collateral resource; refer to Psychiatrist
- 24-hour watch (family and friends); may entail breaking confidentiality/establishm ent of a safety plan, provide suicide hotline number
- Emergency hospital numbers, safety team monitors medications)
- Encourage voluntary hospitalization (talk with client re: procedures)
- Involuntary hospitalization 5150 (Call PET team or police)

Dangers to Others

How would you clinically assess danger to others?

- Specific plan and threat
- Access or possession of weapons
- Identifiable person/place
- Behavioral cues; e.g., pacing rapid speech
- Violence occurring in the client's recent past
- History of family violence.
- Psychological frame for the rage; recent loss, failure of relationship, and/or job
- Psychosocial stressors of a violent environment or employment and residential in

security
- Substance use
- Coping skills; impulse control, anger management
- Not oriented to reality
- Demographics; male clients between the ages of 15-30 and the elderly

How would you manage danger to others?

- Determine if it is a Tarasoff situation; client with serious (imminent threat of "p hysical violence' to a "reasonably identifiable intended victim(s)
- Legal duty to warn: notify the police and the intended victim(s)
- No violence contract
- De-escalation and anger management techniques
- Consider a 5150

How does a mental health practitioner work with a person who may become violent?

Assessing from dangerousness to others is similar in many ways to assessing for suicidal intent. Many of the items considered and the process of developing a plan is similar. Risk assessment for dangerousness is a very important as in the suicide.

Studies have shown that even trained professionals can accurately predict only one out of three episodes of violent behavior.

The following are some basic guidelines for interacting with a person who is potentially violent:

- Get as much information from records on file or other sources before going int o any crisis situation.
- If you believe that a person may have a potential for violence do not interven e alone
- Partner with another crisis responder or involve law enforcement personnel.
- Do not conduct an interview in a room with weapons present.
  If the person is armed, you may wish to ask the person why he or she feels a need to carry a weapon. The person's response to this question may help the responder to formulate a way to request the weapon be put aside with which the person may be willing to cooperate. If a potentially dangerous person refuses to give up the weapon, the mental health practitioner should excuse him or herself and seek assistance from law enforcement officials.
- Do not interview a potentially violent person in a cramped rooms, especially if s/he is agitated and needs to pace. Kitchen, bedrooms, and bathrooms are
- poor intervention sites due to the presence items that can be used to attack

- Be aware of exit routes for yourself and for the person in crisis. A paranoid or agitated person must not feel that they are trapped, and a crisis service provider must have an avenue of escape if the person does become violent.
- Pay attention to the person's speech and behavior. Clues to impending violence include:
  - Speech that is loud, threatening or profane;
  - Increased muscle tension, such as sitting on the edge of the chair or gripping the arms;
  - Hyperactivity (pacing, etc.);
  - Slamming doors, knocking over furniture or other property destruction
  - Use person emergency contacts as necessary.

Do not stay in a dangerous situation!

Get out of the room or other places. Call 911.

When would you consider a 5150 (involuntary confinement)?

- A person who is gravely disabled (unable to take care of their most basic needs) a danger to self or others due to a mental disorder
- Initiate a 5150 by calling P.E.T. (Psychiatric Emergency Team) or police
- A "5150 provide for a 72 hour hold at a psychiatric hospital for treatment and evaluation.
  References:
- Thomas Gordon, P.E.T. Parent Effectiveness Training (1970)
- Gerald Corey, Theory and Practice of Counseling and Psychotherapy(2001)
- Gerry Grossman's Seminars, Workbook (2010)
- Internet sources (Public Domain)

Compiled by Youngja Oh, LMFT

Asian Community Mental Health Services

September 22, 2014

Appendix 3

ACMHS Innovation-PAR

Home-based Referral Log

Name: _____   Gender: _____

DOB: _____   Age: _____

Address: _____

Referred by: _____;   Organization: _____

Date Referral Received: _____

Date of Phone Screening: _____

Clinician's Name: _____

Date of Initial Home Visit: _____

Peer Mentor who made initial home visit with Clinician: _____

Enrolled in Project?   _____ Yes;   Consent Signed: _____ Yes

Pre-Test Completed?   _____ Yes;

Date of Next Social Visit by Peer Mentors Pair: _____

If Not Enroll, Give Reason(s):

_____

Appendix 4

Asian Community Mental Health Services (ACMHS)

310 8th Street, Suite 201, Oakland, CA 94607 (510)-869-6000

Consent to Outreach Visits by Innovation Project Asian Reach Staff and Volunteers

Funded by Alameda County Behavioral Health Care Services

I, the undersigned individual, give permission to ACMHS to exchange information with

_____

(Community-based Organization)

I agree to receive outreach visits by ACMHS Innovation Grant Project Asian Reach staff

and volunteers. I understand all services are free of charge and all personal information

will be kept confidential with the exceptions of mandated reporting covered by

California laws:

- Suspected child, dependent adult and/or elder abuse/neglect
- Suspected intention to harm self or others

The above has been explained to me in _____ (language).

Client's Name: _____

Client's Signature: _____ Date: _____

Project Asian Reach Staff Name: _____

Staff Signature: _____ Date: _____

Asian Community Mental Health Services (ACMHS)

亞裔家庭輔導中心

310 8th Street, Suite 201, Oakland, CA 94607 (510)-869-6000

同意接受外展探訪

Consent to Outreach Visits by Innovation Project Asian Reach Staff and Volunteers

Funded by Alameda County Behavioral Health Care Services

由阿拉米達縣精神健康服務部撥款資助

本人批准亞裔家庭輔導中心與以下機構交換我的個人資料

I, the undersigned individual, give permission to ACMHS to exchange information with

_____

(Community-based Organization)

本人**同意接受**亞裔家庭輔導中心亞裔**外展計劃**的社工和義工

對我的外展探訪。我明白此項服務是完全免費，並我的個人資料是被保密，除以下情況例外，必須按加州法律報告有關當局：

I agree to receive outreach visits by ACMHS Innovation Grant Project Asian Reach staff

and volunteers. I understand all services are free of charge and all personal information

will be kept confidential with the exceptions of mandated reporting covered by

California laws:

- Suspected child, dependent adult and/or elder abuse/neglect
- 懷疑有虐待或疏忽照顧兒童/老人或殘障受照顧成人
- Suspected intention to harm self or others
- 懷疑有想傷害自己或傷害他人

The above has been explained to me in _____ (language).

Client's Name參加者名字: _____

Client's Signature參加者簽名: _____

Date日期: _____

Project Asian Reach Staff Name亞裔外展計劃社工名字: _____

Staff Signature 社工簽名: _____

Date日期: _____

ACMHS

아시안 커뮤니티 정신 건강 센터

Asian Community Mental Health Services (ACMHS)

310 8th Street, Suite 201, Oakland, CA 9460 (510) 869-6000

프로젝트 아시안 뤼치를 위한 직원과 자원 봉사자들이 가정 방문을 하도록 허용하는 동의서

프로젝트 아시안 뤼치는 알라미다 카운티, 정신건강 치료기관에서 나오는 기금으로 제공됩니다.

나는, 밑에 싸인한 사람으로 아시안 커뮤니티 정신 건강 센터와 이 지역 에 있는 기관과 꼭 필요할 때 정보를 나눌수 있도록 허락합니다.

_____

Community-based Organization(이지역에 자리잡은 기관)

나는 아시안 커뮤니티 정신 건강 센터**(ACMHS)** 인노베이션 그랜트**(Innovation Grant),** 프로젝트 아시안 뤼치**(Project Asian Reach)** 직원과 자원 봉사자들이 가정방문을 통해서 제공하는 서비스를 받는 것에 동의합니다. 모든 서비스는 무료로 제공되고 모든 개인 정보는 비밀로 보호되지만 주 정부의 법에 의해서 의무적으로 보고해야 할 몇가지 예외가 있습니다.

- 의심이 가는 아동 학대, 다른 사람의 도움을 받아야 하는 의존적인 어른 그리고, 혹은 노인 학대나 방치
- 자신를 해하거나 다른 사람을 해하려고 하는 것이 의심 될때

위에 있는 사항들을 나에게 <u>한국말</u>로 설명해 주었습니다

고객의 이름:_____

고객의 서명_____ 날짜_____

프로젝트 아시안 뤼치 직원 이름:_____

직원 셔명_____날짜_____

Appendix 5

Asian Community Mental Health Services Innovation Project Asian Reach

Pre/Post-Test Questionnaire

1. Who do you live with?
   a. Live alone
   b. Live with family member/relative(s)
   c. Live with friend(s)
   d. Live with housemate(s)

2. How often do you go out with your family member/relative(s)?

   a. Once every 6 months
   b. Once every 3 months
   c. Once a month
   d. More than once a month
   e. Other: _____

3. How often do you go out with your friends?

   a. Once every 6 months
   b. Once every 3 months
   c. Once a month
   d. More than once a month
   e. Other: _____

4. What do you usually do when you go out with family member/relative(s) or friend(s)?

   a. Health care appointments
   b. Outdoor activities
   c. Shopping trips
   d. Share a meal (e.g. Eating together in a restaurant)
   e. Other activity: _____

5. How often do you attend a cultural, religious or community event such as going to church, temple or senior/community center?

   a. Once every 6 months
   b. Once every 3 months
   c. Once a month
   d. More than once a month
   e. Other: _____

6. What is your main means of transportation?
    a. Walk
    b. Public Transportation (Bus, BART, Paratransit)
    c. Gets a ride from family/friends
    d. Drive

7. How often do your family member/relative(s) or friend(s) visit you at home?

    a. Once every 6 months
    b. Once every 3 months
    c. Once a month
    d. More than once a month
    e. Other: _____

8. How many family member/relative(s) or friend(s) do you have contact on a regular basis?

9. How do you connect with them?
    a. By telephone
    b. Via internet (Email, Social Media/Face Book etc.)
    c. In person

10. How often do you connect with them?

    a. Once every 6 months
    b. Once every 3 months
    c. Once a month
    d. More than once a month
    e. Other: _____

11. What do you do for fun? What are your current hobbies/interests? Please list three.

    _____, _____, _____

12. How often do you engage in these hobbies/interests?
    a. Once every 6 months
    b. Once every 3 months
    c. Once a month
    d. More than once a month
    e. Other: _____

13. What were some hobbies/interests you used to have a year ago but no longer engage in them now?

    _____, _____, _____

14. On a scale of 1 to 10 where 1= Socially Isolated and 10= Socially Connected, how would you rate yourself at this time?

    1   2   3   4   5   6   7   8   9   10
    Socially   Socially
    Isolated   Connected

15. On a scale of 1 to 10 where 1=Sad, 10=Happy, what number would best represent how you feel currently?

    1   2   3   4   5   6   7   8   9   10
    Sad   Happy

16. How often do you feel lonely?

    a. Always
    b. Sometimes
    c. Rarely
    d. Never

17. Who do you turn to for help when you encounter a problem?

18. Is there anything else you would like to share with us?

For Project Staff to complete:

Age of Client: **Client #: _____**

___ 60 or over   ___ 18- 59

Gender:

___ Male   ___ Female   ___Other

Primary Language:

___ Cantonese   ___ Mandarin   ___ Korean   __ English

Date of Survey Completion: _____   Staff Initials: _____

Appendix 6

ACMHS-PAR Initial Screening Tool

Name:
Address:
Phone Number:
Date of Birth:
Age:
Years in U.S.

1. **Who do you live with?**

2. **What is your daily routine?**

3. **Eating and Sleeping Pattern?**

4. **Social Support/Friends?**

5. **Hobby/Recreation?**

6. **Personal Strengths?**

7. **Faith/Spirituality/Religion?**

8. **Health Insurance:**

9. **Primary Care Doctor:**

10. **Medications?**

11. **Alcohol or Other Drug Use?**

12. **Suicidal/Homicidal Thoughts?**

13. **Presenting Problems/Needs**

14. **Three Desired Goals:**

Appendix 7

ACMHS INN-PAR Home Visitation Log

Client's Name: _____

Date of Visit	Duration of Visit	Social Activities	Staff/Peers' Names

Appendix 8

ACMHS INN-PAR Home-Based Outreach Client Discharge Log

Name of Client: _____   **Client's # on Survey: _____**

Gender: _____   **Age: _____**

Primary Language: _____   **City of Residence: _____**

Opening Date: _____   **Closing Date: _____**

Clinician's Name: _____

1. **Post-Test Completion Date: _____**

2. **No Referral Necessary:**

   _____ Has IHSS provider

   _____ Has family support

   _____ Has social network (friends, senior center, senior housing activities etc.)

   _____ Has support of spiritual community (church, temple)

   _____ Other: _____

3. **Referred to the following resources:**

   Community Resources: _____

   APIC-EI or Project Activities: _____

   ACMHS Treatment Programs : _____

   ACMHS Medi-Cal/CalFresh Outreach: _____

4. **Additional Remarks: _____**

   _____

Appendix 9

ACMHS Innovation-Project Asian Reach

Place-Based Community Outreach Log

Date: _____   Location: _____ Staff: _____

Time: _____ to _____   Volunteers: _____

Ethnicity	Language	Adult/Senior?	Name	Phone	Email
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					
14.					
15.					
16.					

Year of the Ram(청양의 해)

Lunar New Year Celebration Luncheon

羊年新春聚餐

(구정 잔치)

日期（날짜）Date: 2/18/2015 (Wednesday)

時間（시간）Time: 11:00AM to 1:00PM
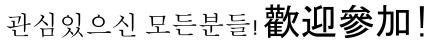
地点（장소）Place: 310-8th Street, Room 101

ART, EXERCISE & GAMES

美術、運動、遊戲小組

미술시간, 운동과 게임‼

星期三早上十時半至十二時

날짜:When: Wednesday, 10:30-12:00 pm

日期：1/28, 2/4, 2/11, 2/18, 2/25, 3/4, 3/11, 3/18

장소:**地点**：Where: South Lake Tower, 1501 Alice Street, Oakland

관심있으신 모든분들! 歡迎參加！

Co-Facilitators: Sunghae Park (510)869-6025 & Jennifer Yu

Appendix 12

Community Resources for Chinese and Korean Seniors in Alameda County

1. Alameda County Meals on Wheels: feedingseniors.org
2. Alameda Meals on Wheels & Friendly Visitors: http://alamedamealsonwheels.org/
3. Asian ACCESS/ACMHS: acmhs.org
4. Center for Elders' Independence (CEI) Centers: cei.elders.org
5. City of Fremont Senior Peer Counseling Program: fremont.gov/219/Emotional-Support
6. City of Oakland Paratransit & Taxi Scrip: alamedactc.org/files/managed/Document/13548/A130049_N_Oakland_TUGO_2014040 8.pdf
7. Crisis Support Services: crisissupport.org
8. East Bay Korean American Senior Center: eastbaykoreanamericanseniorcenter.org
9. Family Bridges Friendly Visitors: fambridges.org/services/friendly-visitors
10. Family Bridges Hong Fook Community-based Adult Services Center: fambridges.org
11. Family Bridges Hong Lok Senior Center: fambridges.org
12. Geriatric Assessment & Response Team (GART): 510-383-5103
13. Korean Community Center of the East Bay: kcceb.org
14. Lincoln Recreation Center Senior Programs: 510-238-7738
15. On Lok, Fremont: onlok.org

BHCS

ALAMEDA COUNTY
Behavioral Health Care Services

MISSION: Our mission is to maximize the recovery, resilience and wellness of all eligible Alameda County residents who are developing or experiencing serious mental health, alcohol or drug concerns.

VISION: We envision communities where all individuals and their families can successfully realize their potential and pursue their dreams, and where stigma and discrimination against those with mental health and/or alcohol and drug issues are remnants of the past.

VALUES: Access, Consumer & Family Empowerment, Best Practices, Health & Wellness, Culturally Responsive, Socially Inclusive.

Alameda County Behavioral Health Care Services

2000 Embarcadero Cove, Suite 400

Oakland, CA 94606

Tel: 510.567.8100, Fax: 510.567.8180

www.acbhcs.org