MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION[1]

County/City: ALAMEDA

☐ Three-Year Program and Expenditure Plan
☒ Annual Update
☐ Annual Revenue and Expenditure Report

Local Mental Health Director	County Auditor-Controller / City Financial Officer
Name: MANUEL JIMENEZ, MA, MFT, DIRECTOR	Name: STEVE MANNING
Telephone Number: (510) 567-8111	Telephone Number: (510) 272-6565
E-mail: MJimenez@acbhcs.org	E-mail: steve.manning@acgov.org
Local Mental Health Mailing Address: 2000 EMBARCADERO COVE, SUITE 400 OAKLAND, CA 94606	

I hereby certify that the Three-Year Program and Expenditure Plan, Annual Update or Annual Revenue and Expenditure Report is true and correct and that the County has complied with all fiscal accountability requirements as required by law or as directed by the State Department of Health Care Services and the Mental Health Services Oversight and Accountability Commission, and that all expenditures are consistent with the requirements of the Mental Health Services Act (MHSA), including Welfare and Institutions Code (WIC) sections 5813.5, 5830, 5840, 5847, 5891, and 5892; and Title 9 of the California Code of Regulations sections 3400 and 3410. I further certify that all expenditures are consistent with an approved plan or update and that MHSA funds will only be used for programs specified in the Mental Health Services Act. Other than funds placed in a reserve in accordance with an approved plan, any funds allocated to a county which are not spent for their authorized purpose within the time period specified in WIC section 5892(h), shall revert to the state to be deposited into the fund and available for counties in future years.

I declare under penalty of perjury under the laws of this state that the foregoing and the attached update/revenue and expenditure report is true and correct to the best of my knowledge.

MANUEL JIMENEZ, MA, MFT
Local Mental Health Director (PRINT)

DEPUTY DIRECTOR
Signature 5/9/2016
Date

I hereby certify that for the fiscal year ended June 30, 2015, the County/City has maintained an interest-bearing local Mental Health Services (MHS) Fund (WIC 5892(f)); and that the County's/City's financial statements are audited annually by an independent auditor and the most recent audit report is dated 12/30/15 for the fiscal year ended June 30, 2015. I further certify that for the fiscal year ended June 30, 2015, the State MHSA distributions were recorded as revenues in the local MHS Fund; that County/City MHSA expenditures and transfers out were appropriated by the Board of Supervisors and recorded in compliance with such appropriations; and that the County/City has complied with WIC section 5891(a), in that local MHS funds may not be loaned to a county general fund or any other county fund.

I declare under penalty of perjury under the laws of this state that the foregoing, and if there is a revenue and expenditure report attached, is true and correct to the best of my knowledge.

STEVE MANNING
County Auditor Controller / City Financial Officer (PRINT)

Steve Manning 5/10/16
Signature Date

[1] Welfare and Institutions Code Sections 5847(b)(9) and 5899(a)

MENTAL HEALTH SERVICES ACT

ALAMEDA COUNTY

FY 2015-2016
PLAN UPDATE

ADOPTED JUNE 7, 2016

CONTENTS

COMPONENT	RESTRICTIONS
Community Services & Supports (CSS)	• No less than 50% must be spent on activities that serve "Full Service Partnership clients"
Prevention & Early Intervention (PEI)	• No less than 20% of total allocation must be spent on PEI • >50% must be spent on activities that serve clients age 25 or younger
Innovation (INN)	• No less than 5% of total allocation must be spent on INN • Must be spent on one-time projects that address a "learning question" with a duration of no longer than 18 months.
Workforce, Education & Training (WET) **Capital Facilities/ Technology (CFT)**	• Ten year spending plan • Can choose to add up to 20% of previous 5-year average CSS to Capital Facilities

MENTAL HEALTH SERVICES ACT (MHSA)

FY 15-16 PLAN UPDATE

SUMMARY OF CHANGES FROM PREVIOUS PLAN (FY14-15)

Alameda County Behavioral Healthcare Services (BHCS) 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, BHCS 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.

I. NEW MHSA PROGRAMS IN PROCUREMENT:

a. Peer Navigator and Crisis Support

This program will offer individual peer support to clients/consumers during care transitions between different levels of care, including discharge from psychiatric hospitals, and provide linkages to primary and behavioral health services and to community resources. An RFP is scheduled to be released in spring 2016.

b. In-Home Outreach Teams

This program will provide home or community-based support and education to clients/consumers, family members and caregivers. Modeled after San Diego County's successful pilot, IHOT focuses on outreach, engagement and support and links participants to services and community resources. Teams will offer services throughout the County including a specialized TAY-focused team. An RFP is scheduled to be released in spring 2016.

c. Community Conservatorship Pilot

This pilot will be based on San Francisco County's Lanterman-Petris-Short Act Community Independence Pilot Project (LPS CIPP) which provides conservatorship, medication, and case management services to clients who have a history of psychiatric hospitalizations and non-compliance with treatment, and who are at risk of re-hospitalization or admittance to a longer-term locked psychiatric facility in the future without proper care. The goal of the LPS CIPP is to provide sufficient supports to enable these clients to live independently and maintain stability. The LPS CIPP program is voluntary and participation requirements are explained to the individual by the treatment provider and their appointed counsel.

d. Assisted Outpatient Treatment (AOT) Pilot

This program provides court-ordered treatment for persons with severe mental illness who meet specific criteria. The program is designed to assist individuals who may not otherwise obtain or maintain treatment. This will be a county-wide 5-client pilot program.

II. EXISTING MHSA PROGRAMS IN PROCUREMENT:

a. Full-Service Partnerships

The Full-service Partnerships (FSP) were the first set of MHSA-funded programs to be implemented upon approval of our Community Services & Supports plan in 2006. This procurement effort will ensure that the most qualified and experienced providers continue to utilize the most effective treatment practices for the populations with the highest-need in Alameda County. Future re-designs and procurement efforts for other MHSA-funded treatment strategies will follow to ensure our programs are responsive to the changing needs of Alameda County consumers and their families.

Target populations:

- Two programs will focus on Transition Age Youth (TAY) including one that addresses consumers experiencing the first-onset of severe mental illness.
- Two programs will focus on Adults (with two additional programs supported by realignment funds.)
- One program will focus on Older Adults (with one additional program supported by realignment funds.)
- A newly-identified priority population will be children and their families.

Recommendations by BHCS-hired consulting group on revenue maximization will be built into the program model to leverage State and Federal dollars to the fullest. The RFP will be release in late summer or early fall 2016. It will take approximately six to five months to have fully negotiated contracts that are approved by the BOS from the date of release.

III. UPDATE ON PLANNING PROCESSES FOR MHSA-FUNDED PROGRAMS:

a. African American Steering Committee for Health and Wellness

The Steering Committee has formed and convened to discuss funding priorities and identified several keys values that shape recommendations for funding.

Broad treatment recommendations:

- Treatment programs funded should be developed and operated for this community by providers with experience in effectively serving this community.
- Funds should be utilized to address the need for housing as the increasing cost of living in Alameda County contribute to difficulties in overcoming historic housing discrimination towards this population.
- The use of clarifying assessments and treatment services by providers with demonstrated skills that advance positive outcomes when working with the African American population.
- Ensure that any implementation of AB1421 is consistent with responding in a culturally responsive manner to African Americans.

Broad prevention and early intervention recommendations:

- Offer the provider trainings developed by the Innovation projects to the broader community.
- Fund mentoring programs to strengthen and build the workforce capacity for African American males.
- Offer specific training to law enforcement to interact with African Americans living with SMI in a more humanizing manner.

b. Community Crisis Planning

For the next quarter the BHCS Executive Team and the Crisis Planning Steering Committee will review the Crisis Planning document with recommendations completed by RDA. Additionally, the Crisis Division Director position was formally announced November 30, 2015 and the hiring process will begin at the end of December. An individual will be selected by end of March 2016.

IV. NEW MHSA REGULATIONS:

a. Anticipated PEI data and outcome requirement and their implications on existing and future PEI programs

In October 2015 the Mental Health Services Oversight and Accountability Commission (OAC) approved new MHSA Prevention and Early Intervention (PEI) regulations. These new regulations, including additional reporting and evaluation requirements, will apply to the MHSA Annual Update for fiscal year 2016-17. Between November 2015 and January 2016, the OAC will be hosting conference calls and in-person regional meetings to review the new regulations and hear from counties regarding various questions and challenges that the regulations have brought to light. While the new regulations will help increase fiscal and programmatic accountability many counties have concerns about the cost of implementation as well as the potential for creating service barriers.

With input from counties, the California Behavioral Health Directors Association (CBHDA) has three main areas of concern including:

1. The component of the PEI regulations stating that counties must use PEI to identify clients who are SMI or SED and refer them to appropriate services (likely CSS), and track their timely access to those services;
2. Measuring the duration of untreated mental illness, including calculating standard deviations, for this same population referenced in #1; and
3. The demographics section.

For the approved and final version of the new PEI regulations please go to this link: http://www.cbhda.org/wp-content/uploads/2014/12/PEI_Final.pdf

Involvement of Community Stakeholders: The participation of community members in the planning process is formalized in the MHSA Stakeholder Group, comprised of and representing consumers, family members and providers. The Stakeholder Group reviews the effectiveness of MHSA strategies, recommends current and future funding priorities, consults with BHCS and the community on promising approaches that have potential for transforming the mental health systems of care and communicates with BHCS and relevant mental health constituencies.

The participating members of the Stakeholder Group are listed in the table below include consumers, family members and providers with key executive leadership:

MHSA STAKEHOLDER GROUP

Name		Seat	Affiliation / Role
Radawn	Alcorn	BHCS	Interim TAY System of Care Director
Penny	Bernhisel	Provider	Telecare Corp.
Aaron	Chapman	BHCS	Medical Director
Gigi	Crowder	BHCS	Ethnic Services Manager
Margot	Dashiell	Family member	Alameda County Family Coalition
Leda	Frediani	BHCS	BHCS Finance Director
Alane	Friedrich	Mental Health Board	Alameda County Mental Health Board
Karen	Grimsich	Provider	City of Fremont
Elsa	Gutierrez	Consumer	Pool of Consumer Champions
Brian	Hill	Consumer	Brian's Online Success Services
Manuel	Jimenez	BHCS	Behavioral Health Director
Janet	King	Provider	Native American Health Center
Sherri	Millick	Family Member	Family Education & Resource Center
Tracy	Murray	Provider	Area Agency on Aging
Pysay	Phinith	Provider	Asian Community Mental Health Services
Jeff	Rackmil	BHCS	BHCS Children's System of Care Dir
Liz	Rebensdorf	Family Member	NAMI East Bay
Yvonne	Rutherford	Family Member	African American Family Support Group
Lillian	Schaechner	BHCS	BHCS Older Adult System of Care Dir
James	Scott	Consumer	Reaching Across
Gwen	Wilson	Provider	G.O.A.L.S. For Women
Cecelia	Wynn	Consumer	Pool of Consumer Champions

The initial draft of the Plan Update was developed by BHCS Executive Leadership, planning staff and fiscal staff in consultation with the Stakeholder Group over a series of meetings in the fall of 2015. BHCS posted the draft Plan on its website for thirty (30) days for public comments beginning on January 11, 2016. The Mental Health Board hosted a Public Hearing on February 8, 2016 at which time BHCS addressed public questions and concerns. BHCS presented to the Alameda County Board of Supervisors Health Committee the Plan at its public meeting on April 11, 2016. Comments were recorded at each meeting and also received electronically through the BHCS website. The final Plan was adopted by the full Board of Supervisors at their June 7, 2016 regular meeting.

FY 2015/16 Mental Health Services Act Annual Update
Community Services and Supports (CSS) Funding

County: Alameda Date: 12/7/15

	Fiscal Year 2015/16					
	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						
1. Homeless Outreach & Stabilization Team	2,344,517	1,634,854	677,663			32,000
2. North County Senior Homeless Program	1,098,606	859,768	188,838			50,000
3. Support Housing for TAY	1,464,308	1,129,550	334,758			
4. Greater Hope Project	1,780,868	1,651,184	129,684			
5. Small Scale Comprehensive Forensic ACT Team	2,159,850	1,570,304	504,546			85,000
6. Transition to Independence	540,079	429,744	110,335			
7. CHOICES for Community Living	3,258,182	3,245,735	12,447			0
8. Transitional Behavioral Health Court ACT Team	1,708,287	1,510,544	197,743			
9. Community Conservatorship Pilot	750,000	750,000				
10. Assisted Outpatient Treatment (AOT) Pilot	150,000	150,000				
11. Housing Services	5,535,838	5,047,322	488,516			
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
Non-FSP Programs						
1. Mobile Integrated Assess Team for Seniors	589,122	408,787	102,468			77,867
2. Crisis Response Program - Capacity for Valley and Tri-City	541,792	325,075	216,717			
3. MH Court Specialist Program	393,772	294,541	99,231			
4. Juvenile Justice Transformation of Guidance Clinic	361,729	245,621	82,934			33,174
5. Multisystemic Therapy	640,222	482,879	157,343			
6. Crisis Stabilization Service	3,897,504	1,181,141				2,716,363
7. Co-Occurring Disorders Program	720,876	671,066	49,810			
8. Residential Treatment for Co-occurring Disorders	3,282,300	2,661,947	379,372			240,981
9. Low Income Health Plan Pilot	6,024,037	3,012,018	3,012,019			
10. Individual Placement Services	3,437,828	2,702,552	685,276			50,000
11. Wellness Center	3,693,941	2,771,399	922,542			
12. Community-Based, Voluntary Crisis Services	1,996,794	1,996,794				
13. BH and Developmental Disability Integration Program	351,461	351,461				
14. Behavioral Health - Primary Care Integration Project	6,883,293	6,583,687	299,606			
15. Culturally-Responsive Treatment Programs for African-Americans	1,000,000	1,000,000				
16. In Home Outreach Team	1,300,000	1,300,000				
17.	0					
18.	0					
19.	0					
CSS Administration	7,549,116	5,587,353	1,961,763			
CSS MHSA Housing Program Assigned Funds	0					
Total CSS Program Estimated Expenditures	63,454,321	49,555,325	10,613,611	0	0	3,285,385
FSP Programs as Percent of Total	42.0%					

FY 2015/16 Mental Health Services Act Annual Update
Prevention and Early Intervention (PEI) Funding

County: Alameda

Date: 12/7/15

	Fiscal Year 2015/16					
	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						
1. Early Childhood (Birth-8) Mental Health Prevention	1,529,819	1,529,819				
2. School-Based Mental Health Consulation in Elementary & Middle Schools	2,042,819	2,042,819				
3. Stigma & Discrimination Reduction Campaign	1,137,663	1,137,663	0			
4. Outreach, Education & Consultation for the Latino Community	1,108,222	1,108,222				
5. Outreach, Education & Consultation for the API Community	1,186,109	1,186,109				
6. Outreach, Education & Consultation for the So. Asian/Afghan Community	662,394	662,394				
7. Outreach, Education & Consultation for the Native American Community	282,944	282,944				
8. Suicide Prevention and Trama-Informed Care	1,435,493	1,285,493	150,000			
9. Wellness, Recovery and Resiliency Services	2,328,949	2,238,139	90,810			
10. Family Education Center	1,493,848	1,493,848				
11. Staffing to Asian Population (ACCESS)	772,784	700,176	72,608			
12. Staffing to Latino Populations (ACCESS)	622,765	525,567	97,198			
13. TAY Resource Centers	851,487	851,487				
14. Adult and Older Adult Peer Support	1,035,000	1,035,000				
15. Culturally-Responsive Programs for the African-American Community	1,200,000	1,200,000				
	0					
	0					
PEI Programs - Early Intervention						
11. Early Intervention for the Onset of First Psychosis & SMI Among TAY	1,344,629	1,115,339	176,378			52,912
12. Mental Health-Primary Care Integration for Older Adults at ERs	751,951	650,962	100,989			
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
PEI Administration	4,520,877	3,871,002	649,875			
PEI Assigned Funds	342,215	342,215				
Total PEI Program Estimated Expenditures	24,649,968	23,259,198	1,337,858	0	0	52,912

FY 2015/16 Mental Health Services Act Annual Update
Innovations (INN) Funding

County: Alameda Date: 12/7/15

	Fiscal Year 2015/16					
	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. Innovation Grant Project	3,809,636	3,809,636				
2.	0					
3.	0					
4.	0					
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	814,778	814,778				
Total INN Program Estimated Expenditures	4,624,414	4,624,414	0	0	0	0

FY 2015/16 Mental Health Services Act Annual Update
Workforce, Education and Training (WET) Funding

County: Alameda Date: 12/7/15

	Fiscal Year 2015/16					
	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. WET Development, Support and Coordination	730,630	599,117	131,513			
2. The ACBHCS Training Institute	209,971	209,971				
3. Peer Employment Toolkit	6,000	6,000				
4. Community College Pathway	0	0				
5. Diversity and Language Capacity	150,000	150,000				
6. Development of a Coordinated Intership Program	1,000	1,000				
7. Development of a Financial Incentives Program	0	0				
8. Graduate Level Stipend Program to Increase Workforce Diversity	210,000	210,000				
9. Loan Assumption Program	0	0				
10.	0					
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	1,307,601	1,176,088	131,513	0	0	0

FY 2015/16 Mental Health Services Act Annual Update
Capital Facilities/Technological Needs (CFTN) Funding

County: Alameda Date: 12/7/15

	Fiscal Year 2015/16					
	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 Programs - Capital Facilities Projects						
1.	0					
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
CFTN Programs - Technological Needs Projects						
11. Behavioral Health Management Information System	6,093,286	6,093,286				
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
CFTN Administration	180,308	147,853	32,455			
Total CFTN Program Estimated Expenditures	6,273,594	6,241,139	32,455	0	0	0

A. COMMUNITY SERVICES & SUPPORTS PROGRAM SUMMARIES

Full Service Partnership (FSP) Programs: The following measures are being adopted by all full service partnership programs and included in future contract language:

Outcome Measures:

1. At least 85 percent of clients (50% for TAY) shall have a primary care within 12 months of enrollment, after being enrolled for at least 12 months.

2. 80 percent of clients shall be in long-term, stable housing within 24 months of enrollment.
    A. Among FSP partners enrolled for at least six months, more than 80% of them at any point in time will be in a known and non-institutional living arrangement (General Living Arrangement or Supervised Placement).
    B. Among FSP partners enrolled for at least six months, at least 60% of partners will have a current living arrangement that is more independent and less restrictive than their living arrangement at the time of admission into the FSP program (Measure based on the FSP housing hierarchy established by the BHCS Housing Services Office and attached).

3. Client use of psychiatric hospitalizations and emergency services shall decrease 50 percent post-enrollment, compared to data for 12 months prior to enrollment.

4. The number of partners incarcerated shall decrease 55 percent within 12 months of enrollment, compared to 12 months prior to enrollment.

5. Employment & Education (being developed further)

Process Measure:

6. 90 percent of the clients who enter the program shall have Medi-Cal application or reinstated benefits within three months of program enrollment. 80 percent (60% for TAY) of the clients who enter the program shall have Supplemental Security Income (SSI), or an open application for SSI, within six months of program enrollment.

A. COMMUNITY SERVICES & SUPPORTS PROGRAM SUMMARIES

FSP 1. Homeless Outreach & Stabilization Team (HOST)

Program Description: Multi-disciplinary team engages homeless adults and links them to a range of services with a focus on community services, peer support and the means to obtain and maintain housing.

FY 13/14 Outcomes, Impact & Challenges: See **ATTACHMENT B** "HOST Adult Full-Service Partnership Program Outcomes …through December 2014".

FY 14/15 Progress Report: HOST is now utilizing the Alameda County Home Stretch guidelines for screening and assessment of new enrollments. These guidelines ensure that HOST is serving people who are at the greatest need within our target population. HOST has implemented several new groups to assist our partners: Damage Control is a substance use harm reduction group and has 8-10 regular attendees. Men of Impact is a men's group that focuses on empowering men to understand the role that mental illness and substance use plays in their lives and in their community and focuses on healing individuals and the community. A group that is restarting at HOST is Cooking Matters, which teaches partners to shop for and cook healthy meals on a budget.

FY 15/16+ Plans: No significant changes planned. Continued implementation of graduation procedures leading to increased flow of HOST partners to lower levels of care.

A. COMMUNITY SERVICES & SUPPORTS PROGRAM SUMMARIES

FSP 2. North County Senior Homeless Program

Program Description: Multidisciplinary team engages homeless seniors and provides housing with community supports. Provides linkage for family members and offers peer support.

For previous FY 14-15 Outcomes, Impact & Challenges: North County has maintained its expansion goals, consistently connecting with community organizations in search of underserved older adults. We celebrated four graduations in the past six months, with permanent housing found from Oakland to the Philippines. For FY14-15, we celebrated the graduations of over 15% of our participants. Of participants open at year end, 17 (43%) have obtained permanent housing and no longer receive Housing Financial Assistance; they are moving toward graduation. We continue to pursue affordable housing opportunities with 15 participants (38%) utilizing Housing Financial Assistance funds to provide stability in the interim.

A trend with new NCSHP participants related to access of medical and psychiatric services led to an even bigger increase in our medical and psychiatry team needing to meet more participants in their homes to encourage engagement in medication management.

During FY14-15, NCSHP served 43 older adults. The NCSHP team will serve a total of 40 partners at any given time in the coming fiscal year.

During the second half of FY14-15, BACS began meeting with county staff to redesign the medical and psychiatric components of NCSHP. Determining the best structure to continue to provide the high level of care participants have received from medical and psychiatric staff is currently a focus of strategic planning.

For current FY 15-16 Progress Report: The NCSHP team will serve a total of 40 partners at any given time in the coming fiscal year. BACS will explore redesigning the medical and psychiatric components of NCSHP to maintain its current high level of care. BACS is in the process of exploring implementing a monthly supervision group for peer counselors across programs to ensure they are supported in their professional development on an ongoing basis.

The current use of ACT allows clinical and housing staff to provide a high level of care to all participants in the NCSHP.

For upcoming FY 15-16+ Plans: No significant changes planned.

FSP 3. Supportive Housing for Transition Age Youth (STAY)

Program Description: Provides permanent supportive housing for youth who are homeless, are aged out of foster care, leaving the justice system or residential treatment.

For previous FY 14-15 Outcomes, Impact & Challenges: STAY served 55 participants during the fiscal year who were homeless or at risk of homelessness and living with a significant mental health disability. As evidence of working towards our objective of assisting participants with maintaining housing stability, of the 55 served: 31 (57%) were placed in and maintained either permanent or long-term transitional housing. During this period STAY discharged 14 and of the 14:

- 8 (57%) were planned discharges
- 5 (36%) exited the program with permanent housing.
- 11 (78%) exited the program and went to a lower of care.

During this period progress was made with regard to competitive employment through our evidenced-based practice employment program, Individual Placement Support/Supported Employment (IPS). During the year 18 STAY participants were enrolled in IPS, 13 were employed at some point during the year and 3 of the 13 were employed consistently for the entire fiscal year. More specifically, The IPS program achieved a rating of good fidelity (highest rating since IPS program's inception in 2012) and maintained an employment rate for IPS enrolled participants ranging from 23 - 43% each quarter of the fiscal year.

During the fiscal year STAY again implemented two Dialectical Behavioral Therapy (DBT) groups to assist participants with managing mental health symptoms as well as our ongoing Drop In Group for TAY that focuses on Independent Living Skills, peer connection and support, and improvement of activities of daily living.

A few highlights of the year included: One participant who had never maintained a placement for more than 3 months and had an ongoing history of frequent psychiatric hospitalization was able to maintain housing in his own apartment and stay out of the hospital for the entire year. The program achieved objective of increasing the number of participants linked to primary health care. The program saw an increase in collaborative treatment involving other providers and behavioral health systems of care for high acuity/high need participants.

The increasing rent and high demand for rental housing in the area have slowed the process of placing STAY participants in independent housing. Participants living with their families but developmentally ready to live on their own, have waited longer for placements in the community due to the increasing scarcity of suitable, affordable rental units. Additionally, the program experienced challenges with finding residential, day treatment and/or substance abuse treatment resources within the community specifically designed for managing high acuity participants who needed crisis stabilization support that would augment STAY services.

For current FY 15-16 Progress Report: In the upcoming fiscal years STAY is contracted to serve 50 participants at any point in time. STAY will continue to support overall outcome goal of improving the participant's condition and/or life through the services we provide. STAY will continue to focus on increasing the number of participants that retain housing as well as supporting participants with achieving their employment goals.

A. COMMUNITY SERVICES & SUPPORTS PROGRAM SUMMARIES

For upcoming FY 14-15, FY 15-16, FY16-17 Plans:
Greater HOPE will continue to target housing, case management, mental health, psychiatric, vocational rehabilitation and primary care services to 43 severely mentally ill adult participants

The program will be moving to Hayward within the next 6 months. As we move people out of Southern and Eastern Alameda county into more affordable housing in Central and Northern Alameda County, the program will be more centrally located and thus be accessible to program participants.

Greater HOPE also will continue to consider strategies to address the need to broaden our efforts within the scope of available resource.

FSP 5. Forensic Assertive Community Treatment (FACT)

Program Description: FACT is a full service partnership (FSP) program of the East Bay Community Recovery Project and is contracted with Behavioral Healthcare Services to provide services to and maintain an active caseload of 70 adult participants (age 18-59). FACT has been providing housing and wraparound supportive services to individuals identified by the county as persons who continue to cycle in and out of psychiatric emergency and inpatient services and Santa Rita jail. The program provides an intensive level of services to the individuals enrolled in the program, partners, to encourage and support their wellness and recovery efforts with the goal of significantly reducing or eliminating the need for psychiatric emergency or inpatient services number or serving jail time.

For previous FY 14-15 Outcomes, Impact & Challenges:

Number of Partner served: **76** Number of new enrollments: **6** Number of transitions: **6**

1. Primary Care: 92 % of partners were connected with primary care within 12 months of enrollment. The remaining 8% of the partners have yet to complete 12 months in the program.

2. Housing (24 months): 83% of the partners have been placed in long-term stable housing within 24 months of enrollment
   a. Housing (enrolled at least 6 months): The program, on average, has 85 % of the active partners at any given time in a known and non-institutional living arrangement (general living arrangement or supervised placement)
   b. Housing (enrolled at least 6 months): The program, on average, has at least 84% of the partners reporting that their current living arrangement that is more independent than their living arrangement at the time of admission into FACT. The next significant group would be the partners who were stably housed on enrollment into the program and who were stably housed when reporting their current living situation.

3. Hospital Episodes:
   - 12 months Prior to enrollment:131
   - First 12 months of enrollment: 58
   - Decrease in hospital episodes: 56%

   a. Hospital Days
   12 months Prior to enrollment: 1178
   First 12 months of enrollment: 469
   Decrease in hospital days: 709 or 60%

b. PES Episodes
12 months Prior to enrollment: 359
First 12 months of enrollment: 260
Decrease in PES episodes: 99 or 28%

4. Incarceration Episodes*
12 months Prior to enrollment: 259
First 12 months of enrollment: 128
Decrease in Episodes of Incarceration: 131 or 51%

a. Incarceration Days
12 months Prior to enrollment: 7235
First 12 months of enrollment: 2881
Decrease in days of Incarceration: 4354 or 60%

5. Employment and Education (47 partners participated during this reporting period)
In the last year, new partners interested in either employment or education were initially referred by team members to meet with the employment and education specialist. The specialist ensured that all partners referred for either employment or educational services were assessed using the Dartmouth IPS assessment. Because the assessment is so thorough, it typically takes three sessions to complete. All partners who were referred expressed an eagerness to start working. Many of them also expressed an interest in wanting to go back to school to obtain their GED, high school diploma or sometimes college courses.

This fiscal year, we started the Home Management Training Program. This program was made available to the residents of Milton and Mead permanent housing. All residents take turns being the “trainee of the week,” in hopes of establishing their ability to work in the resident property management field. Their work week starts on Thursdays at 3pm and extends through Thursday 3pm of the following week. House meetings are held every Thursday, in order to support the transition from one partner to the next in rotation. This meeting is attended by staff persons from the property management and Employment departments at EBCRP. At this meeting, the next partner in the rotation will be made aware of all matters that have been reported to FACT / TrACT staff. Attendance is compulsory for partners living in each of the houses. All partners who may fit the criteria of moving into Milton / Mead housing will need to be enrolled in the Ticket to Work (T2W) and Plan to Achieve Self Support (PASS) programs, so that any wages they earn won’t impact their SSI payments. Once they start working, the Earned Income Exclusion of $65.00 (under SSI) will be applied, regardless of their T2W or PASS status. ES works in collaboration with the housing staff, to rule out the Shelter Plus Care eligibility with partners, following their initial housing assessment. ES then administers the Dartmouth IPS Assessment with the partner. Employment Specialist works with PSCs to ensure IDs and SSI cards are obtained. Employment Specialist will get all payroll paperwork completed with partners. Partners are paid $64 ($15/hour – i.e. minimum wage in Oakland) for approximately 5 hours of work and training per each week they participate in the training program. It is mandatory that all partners living at the Milton and Mead houses participate in the program.

a) Employment participation (33 of 47 or 70% of these partners chose the employment path)
- 19% of the partners were placed in competitive employment
- 13% of the partners were engaged in supported employment
- 38% of the partners were participating in Job training programs

b) Education participation (7 of 47 or 30% of these individuals chose the education path)

- This reporting period there were 7 individuals pursuing some form of continuing education from a G.E.D. to college courses.

- In Section I the positive impact of the FACT program is demonstrated through the reduction in partner recidivism to psychiatric hospitals, psychiatric emergency services and jail. The most notable impact is the following outcome not covered in section I: The number of partners remaining in the community with no jail time since enrolling in the criminal justice behavioral health FACT program = 23 or 27%. Partner involvement in the program Education and Employment services continues to positively impact or be a good indicator of a partner's ability to succeed in achieving their wellness and recovery goals. The partner that is successful in completing an education goal or demonstrates the ability to maintain in competitive employment further confirms our beliefs that our partners are capable and can succeed in whatever goal they put their mind and efforts into achieving.

- The FACT program of the East Bay Community Recovery Project has positively impacted the west Oakland neighborhood, families, and the community by instilling hope, where all hope had been lost and or forgotten, for the families impacted by the effects of alcohol and drug abuse, mental health and criminal activity. The community based facility has been providing easily accessible in-house or in your house individual, group and family intervention and treatment services that are compassionate, non-judgmental and confidential to facilitate individual recovery and wellness and to create an opportunity for healing families and communities. Saving costs through the reduction in the utilization of psychiatric emergency and inpatient, and jail services has been an outcome of the program enabling the system to shift funds into more efforts for prevention and support proactive measures and programs that aim to keep individuals from ever having to utilize these systems.

- A cost benefit analysis would reveal a large savings to the jail, psychiatric emergency services, and the psychiatric hospitals when compared to the costs to run the FACT program. Next steps would be to identify these savings and put those funds into prevention programs to promote education.

For FY15-16, 16-17 Plans:
Continue implementation and graduation plan for partners.

A. COMMUNITY SERVICES & SUPPORTS PROGRAM SUMMARIES

FSP 6. Transition to Independence (TIP)

Program Description: Provides intensive mental health services to transition-age youth who are experiencing severe mental illness, aged out of foster care, leaving the justice system, or residential treatment.

For previous FY 14-15 Outcomes, Impact & Challenges: For this FY, TIP served a total of 33 clients. According to FSP Indicator Report, 27 clients completed at least one (1) full year of FSP and of this number, we achieved the following:

- Mental Health Emergency Events: 33.3% clients compared to 66.7% the year before
- Psychiatric Hospital Days: 4.1% compared to 2.3%
- Jail: 0.2% compared to 0.8%
- Residential Treatment: 8% compared to 1.8%
- Employment: 6 clients employed (competitive and supported) compared to 0 at the start of partnership; 1 client participates in YEAR UP program
- Education: 1 client enrolls in 4 year college; 4 clients enroll in community colleges; 1 client enrolls in high school
- Primary Physician: 83.3% had physician compared to 50% at start of FSP
- Residential setting: 25.9% live alone in his/her apartment compared to 14.8% the year before

During this reporting period, two of our clients graduated from Berkeley High School and one is a full time student at Mills college. Prior to participating in our program, all three clients had many psychiatric hospital admissions and there were little hope that they could stabilize in the community. Not only did they stabilized with no psychiatric hospital admissions, they were able to complete and graduated. All three are on track to be discharged to lower level of care in the upcoming months.

While the program was able to reduce psychiatric hospital admissions for most of our clients, TIP was challenged with the high needs of two clients who continued to require more intensive and structured interventions as in hospital settings. As a result, our data showed an increase in number of psychiatric hospital days during FY 14-15. It should be noted that these two clients also participated in PREP for two years prior to being transferred to TIP for continuing care and had established similar patterns of high usage of hospitals. Another challenge to the program was the fact that TIP is a small team with four multidisciplinary staff and services were hampered during the months of Feb 2015 through June 2015 due to two staff's emergency medical leaves. Lastly, affordable housing in Alameda County continues to be a challenge due to low vacancy rates and landlords are much less willing to rent to clients with subsidized housing vouchers.

For current FY 15-16 Progress Report: TIP staff have returned to full capacity as of July 2015 and that should reflect an increase in clients' care and enrollment. TIP plans to enroll up to 35 TAYs per year. TIP is in the process of transitioning 6-7 clients to lower level of care. Simultaneously, we continue to provide supportive and assertive outreach to new referrals. TIP is also actively using 211 and Housing Choices website to assist our clients finding affordable or subsidized housing options.

For upcoming FY 16-17+ Plans: TIP will continue to support the transition of TAYs to independent living by reducing frequency of psychiatric hospitalizations, increasing completion of educational and employment goals, and expanding services to 35 TAYs per year.

FSP 7. CHOICES for Community Living

Program Description: This FSP is a transformational program for Service Teams that integrates supportive housing, supportive employment, peer counseling and strength-based and person-centered case management to enable clients to graduate into a fuller life in the community without the need for the Service Team.

FY 13/14 Outcomes, Impact & Challenges:

- In January 2014, a third cohort of sixty (60) Partners from five Service Teams received their orientation and began their journeys of recovery with targeted IPS Supported Employment, Supported Housing, Peer Support and Strength-based Case Management Services.
- CHOICES celebrated its second graduation event on November 6th, 2014 with forty-five (45) Partners from the second cohort who successfully completed the program. Partners and their families continued to express pride in their accomplishments. Partners each had an opportunity to share about their experience, strength and hope for their lives.
- Of those Partners who completed the program, thirty (30) were fully discharged from their team. Fifteen (15) Partners required some additional supports from their team while continuing to work on employment, housing and recovery goals.
- The CHOICES Program Manager resigned her position and no new position was approved in May 2014.
- Initial staff challenges in implementing program design, formalizing policies and supporting inter-agency and inter-disciplinary collaboration. These challenges were present in year #1 and resolved by year #3.
- Related to the staff challenges were Partner challenges in understanding and accessing the various program domains.
- Turnover in program staff has continued to present a challenge.
- Premature disenrollment/attrition has continued to present a challenge on some teams.

Housing Services Outcomes:

- Of the 111 Partners who utilized housing services a majority (75%) met at least minimum consumer-defined preferences for the type of housing they wish to achieve.
- Of all Partners, 64% maintained or improved their residential living status during the program and 69% were still in an independent living situation as measured by key event tracking.
- However, 20% of Partners' residential status became worse (and another 16% of Partners data were not tracked.) Concerns were raised that either Partners housing needs were not fully addressed or other environmental factors created barriers for some Partners to achieve better housing.

Employment Services Outcomes:

- Employment Specialists elicited initial consumer-defined employment goals and annually tracked achievement. In three areas of consumer-stated preferences for employment, a majority of Partners met their goals: type of work (62%), amount of work (60%) and type of follow-along support services (63%).
- There was a 350% increase in the number of Partners who achieved a competitive employment job placement during the CHOICES, compared to their employment status upon enrollment.
- Of the 110 Partners who sought IPS services, 57% had at least one job placement during CHOICES.
- A sizeable majority (73%) of these Partners held job placement longer than 90 days.

Wellness, Recovery and Resiliency Outcomes:

- From the annual surveys measuring wellness and functioning, Cohort 2 showed improvement in nine areas and Cohort 1 in three areas. Neither Cohort had any declines of wellness as measured by repeated surveys. Client satisfaction was moderately high for both Cohorts, although Cohort 2 satisfaction scores were higher than those of Cohort 1.
- Partners rated the quality of the Learning Center classes and events very high: Cohort 1 (77%), Cohort 2 (86%) and the convenience of the Learning Center, such as location, times of operation and availability of services: Cohort 1 (71%), Cohort 2 (90%).
- Partners rated the quality of support highest with Personal Service Coordinators at (85%) for Cohort 1 and (86%) for Cohort 2.
- The Partners rated the quality of support from the Peer Support Staff second highest at (81%) of Cohort 1 and (83%) for Cohort 2.
- Well-being outcomes and client satisfaction as measured by the annual surveys showed that Cohort 2 Partners may have benefitted from the program more than Cohort 1. This may have been the result of program maturity.

Challenges:

- A total of 113 Partners (84%) went through the CHOICES Program without any hospitalizations. CHOICES Partners were not “immune” from being hospitalized or re-hospitalized. Twenty-two (22) Partners (16%) needed at least one psychiatric hospital admission during CHOICES. Of these, twelve (12) had previous hospitalizations during a 5-year period prior to enrollment in CHOICES. While all partners were followed closely by program staff during hospitalizations, the average length of stay was an average of 1.5 days higher compared to pre-CHOICS hospital experience.
- Twelve Partners were reported to be incarcerated while enrolled in CHOICES.
- Ten (10) Partners who were hospitalized and two (2) that were incarcerated had favorable residential outcomes either returning to or securing new independent living situations.
- According to program staff when reviewing these events with evaluators, the most difficult and intransigent problems were for Partners who had a combination of drug/alcohol abuse, housing instability and involvement with the criminal justice system.

Team Facilitation and Accountability:

- “The availability of the multi-disciplinary team which was structured around Partners preferred recovery goals most likely facilitated the success of the Employment Specialists in addressing barriers to preparing Partners for job interview and maintaining employment”, according to the final CHOICES evaluation report.
- In addition, the CHOICES final evaluation report states, “Respondents also pointed to indications that the team structure was contributing to a change in culture of the participating service teams – i.e. The potential of disseminating a recovery orientation beyond the PSC’s whose consumers participated in CHOICES.”

Staff/Systems Change Outcomes Reported but not Quantitatively Measured:

- Promising results in the areas of housing, employment and some indicators of wellness.
- Peer mentors played an invaluable role with many Partners in helping to provide solutions to problems that might not be apparent to other professionals. They were instrumental in helping with employment related issues; as well as issues related to treatment adherence, solving housing dilemmas and assisting with community integration.
- Resolution of most of the challenges present during year #1.

- Adoption of a recovery orientation among program staff that has extended to staff not directly involved with CHOICES.
- Meaningful and productive collaboration amongst Recovery Coaches, Housing and Employment Specialists, and Personal Service Coordinators.
- Housing stipends were effective for a sub-population of consumers whose housing stability was especially poor, who were motivated to make a housing change and were also interested in pursuing strategies for long-term income stability such as competitive employment.
- An overall sense of satisfaction with the program by Partners who remained enrolled.
- Commitment of program leaders and staff to continuous quality improvement.
- Given the high satisfaction rates with the Peer Recovery Coaches and the Learning Center, a wellness and recovery center is an important resource for consumers who need further support once they achieve increased levels of independence.

FY 14/15 Progress Report:

- Continue and promulgate the IPS employment model.
- Establish cross-disciplinary teams for those consumers whose level of functioning requires more intensive case management, while keeping in mind that consumers who may be ready for employment might nevertheless experience increased anxiety and setbacks in functioning as they approach job interviews or other life changes such as new housing.
- Develop criteria for the more targeted use of housing stipends, should that resource be made available.
- Resource Service Teams with Peer Mentors who can assist with navigating primary care system, community integration, provide WRAP classes, as well as other wellness/recovery activities to support consumer recovery goals.

FY 15/16 Plans:

- A decision was made by BHCS administration to discontinue the CHOICES Program. Those Partners engaged with Housing rental subsidies and employment services were allowed to continue with those supports through the end of the three year enrollment. Teams worked to transition Partners back to the teams to continue to work on their recovery goals. A final celebration was held at the CHOICES Learning Center on May 20th, 2015 to end the formal CHOICES Program and celebrate the accomplishments of the Cohort 3 Partners.

FY 16/17 Plans:

- Co-locate IPS supported employment staff with Service Teams and offer competitive employment services to all consumers served on teams.
- Continue work to resource each team with Peer Mentors with a clear set of competencies and responsibilities to support consumer recovery and community integration goals.
- Continue to advocate for supported housing staff and affordable housing resources for motivated consumers to move into independent housing.
- Recommend Peer Support staff hired to monitor and evaluate programs with more targeted brief data collection procedures and focus groups.
- Recommend to continue to provide ongoing staff development training in strength-based case management, person-centered care planning and co-occurring substance abuse treatment approaches.

FSP 9. Behavioral Health Court (BHC), Transitional Assertive Community Treatment (TrACT) Team

Program Description: TrACT is a full service partnership (FSP) program of the East Bay Community Recovery Project and is the dedicated service provider for the Alameda County Behavioral Health Court. TrACT is a program sub-contracted with Behavioral Healthcare Services to provide services to and maintain an active caseload of 20 adult (age 18-59) participants. TrACT has been providing intensive wraparound mental health, co-occurring substance use and other health related services to participants of the court program since August 2009. This court-supervised program is for adult individuals arrested in Alameda County and are awaiting their court appearance either in custody or in the community and have chosen to participate in the court program instead of having their cases proceed in the regular court process. Eligibility for the program requires that the individual or potential BHC participant have a mental health condition that is severe in degree and persistent in duration. This condition has to have been a determining factor for the commission of their crime. A partners charge or qualifying charges, as related to their alleged crime, are either reduced from a felony to a misdemeanor or dismissed from their record with their successful completion of TrACT and the BHC program.

For previous FY 14/15 Outcomes, Impact & Challenges:

Number of Partner served: **45** Number of new enrollments: **20** Number of transitions: **13**

1. Primary Care: 90 % of partners were connected with primary care within 12 months of enrollment. The remaining 10% of the partners have yet to complete 12 months in the program

2. Housing (24 months): 100% of the partners have been placed in long-term stable housing within 24 months of enrollment (for the TrACT, which is only a 12-month program, this refers to partners who were doing well in the program and were most likely on their way to completing the program at 12-months' time).
   a. Housing (enrolled at least 6 months): The program, on average, has 89 % of the active partners at any given time in a known and non-institutional living arrangement (general living Arrangement or supervised placement).
   b. Housing (enrolled at least 6 months): The program, on average, has at least 84% of the partners reporting that their current living arrangement that is more independent than their living arrangement at the time of admission into TrACT. The next significant group would be the partners who were stably housed on enrollment into the program and who were stably housed when reporting their current living situation

3. Hospital Episodes*

12 months Prior to enrollment:	13
First 12 months of enrollment:	3
Decrease in hospital episodes:	77%
a. Hospital Days	
12 months Prior to enrollment:	59
First 12 months of enrollment:	23
Decrease in hospital days:	61%
b. PES Episodes	
12 months Prior to enrollment:	33

First 12 months of enrollment:	7
Decrease in PES episodes:	79%

4. Incarceration Episodes*

12 months Prior to enrollment:	27
First 12 months of enrollment:	4
Decrease in Episodes of Incarceration:	85%

a. Incarceration Days

12 months Prior to enrollment:	942
First 12 months of enrollment:	82
Decrease in days of Incarceration:	91%

*Data was collected from Insyst for the 17 participants that were enrolled, active and had completed at least 12 months in TrACT.

5. Employment and Education

(22 of the active 45 partners for the reporting period)

Since TrACT partners are with the program for a shorter period of time (12 months), most partners were more interested in going back to school or getting some form of job training. An MOU was made with the Cypress Mandela Training Center, which offered a 16-week pre-apprenticeship program for Bay Area men and women over 18 years' old who have a physical or mental disability. Training is both hands-on and in the classroom and prepares partners for skilled trades jobs relevant to today's construction industry. Another skills training program that partners seem to be keen to participate in is the 16- week ATLAS forklift program, which is in collaboration with Alameda College. Both of these training programs were more in line with the IPS objectives, there were fewer partners participating in supported employment related services this year. On a positive note, there was an increase in the number of partners who were interested in supported education related services and competitive employment.

a. Employment participation

- Competitive employment had 4 individuals placed
- Supported employment had 3 individuals participating
- Job training had 7 individuals participating

b. Education participation

- This reporting period there were 8 individuals pursuing some form of continuing education from the GED to college courses.

II. TrACT Program Impact

The TrACT programs positive community impact, as far as reduction in recidivism—cost for services related to psychiatric emergency, impatient and criminal justice jail services—the statistic shown above in section 1-5 above. The program partners were able to significantly increase their time living in the community mostly free from the paralyzing mental illness related symptomatology experienced that in the past would require a partner to voluntarily or sometimes be forced to access and or utilize psychiatric emergency services, inpatient hospitalization or incarceration to stabilize psychiatrically and behaviorally. Now, the partners are creating new histories for themselves and, as briefly discussed in section 5 above, have become active members participating in and contributing to their communities of choice by living independently and participating in various forms of meaningful activities that contribute to their well-being and the wellbeing of the community at large.

One particular TrACT graduates story demonstrates the positive impact that the many services of the TrACT program can contribute to the wellness and recovery of an individual's life. This TrACT graduate had been homeless for 3 years, estranged from his family, suffering from alcohol addiction and severe mental health issues complicated by involvement in the criminal justice system. His recovery involved the program supporting him to; obtain the tools ad medication for addressing his mental health issues, reunite with his parents, achieve long-term sobriety, have his legal charges dismissed, obtain competitive employment, his applying to and being accepted into graduate school, subsidized housing and a new lease on life. The program was able to support this individual to enroll in social security's' Plan to Achieve Self Support (PASS) Program. This enabled him to work while receiving his full SSI benefit and save the money he was making from his employment to put towards school. Additionally, he received money from the PASS Program to support his paying for books, tuition and a car to help him get to and from work, school. This individual volunteers some his time for a non-profit in the bay area and will be studying at a prestigious university to pursue his degree in the field of social welfare as he hopes to be able to give back to the community that supported him when he had nothing.

III. FACT and TrACT - Program Challenges and Strategies

A. Program Challenges and Strategies to mitigate these challenges

1a. Challenge - Partner Substance Abuse - The FACT and TrACT programs, providing services since 2007 and 2009 respectively, have experienced challenges to achieving the milestones /outcomes (independent living, employment, education, transition of services to a lower level of care, etc.) that the programs are expected to meet and our funders measure to determine the program's success. The primary challenge to the program meeting its outcomes continues to be the pervasive and chronic substance use/addiction that plagues a majority, 89 % (84 of 92), of the overall program partners. The FACT partner's substance use is more significant both in actual total number of partners served and the severity of use when compared to the Behavioral Health Court TrACT partners. Partners substance use/ addictions compromises their ability to adhere to basic program instruction or guidelines whether it is taking medication as prescribed or following through with orders from the court. Substance use diminishes a partners functioning capacity which in most cases keeps them from being able to utilize and benefit from the many resources and opportunities available to them from these MHSA funded programs.

The programs have access to the few co-occurring residential programs as we have developed close partnerships with these programs over the years. Along with numerous other programs in the county we refer our partners for the few residential treatment beds available for these individuals struggling in their substance addiction and in need of a structured rehabilitation program. FACT and TrACT partners' mental health and co-occurring substance abuse treatment needs have continued to increase each year while the existence and or availability of other co-occurring community resources—residential treatment programs, sober living environments (housing), intensive outpatient and self-help services—continues to fall short of the need. The programs often have to resort to referring partners to residential treatment services that are only intended for individuals with substance use issues and do not have the capacity or ability to treat individuals with co-occurring severe and persistent mental health issues.

The program's success rate of graduating partners would be exponentially higher if there were substantially more co-occurring substance abuse residential programs, step-down community based recovery support and self-help programs that complement the therapeutic and rehabilitative services of FACT and TrACT. The outcome of such a system of care would provide longer term

comprehensive services and or support individuals with their efforts to maintain their personal program for recovery, increase their sober community network and to create a sober history. These challenges, experienced by partners along with the absence of a comprehensive mental health and co-occurring substance use treatment and services continuum of care in this county, significantly decreases the program's capacity for effectively supporting partners in achieving program milestones and successfully achieving their wellness and recovery treatment goals.

1b. Strategy - Fortunately, there have always been a percentage of partners who have been able to achieve and maintain their sobriety, achieve and maintain competitive employment, complete the program and live independently in the community. We looked at the elements of these individual's success and began to look at what we could do to increase partner success.

We conducted an internal program review and evaluation (this included feedback/input from our partners and collaborating provider programs) of the efficacy of program services offered and from this began the process of "change" and program improvement. This change process was an opportunity to specifically target the challenge of partner substance abuse issues. Our strategy consisted of a restructuring the program staffing pattern—updated the required skills and experience of incoming employees—and redesigning the program curriculum to increase our ability to address substance abuse, risk and criminal behaviors /criminogenic needs as well as mental health. This has led to an introduction of increase and refocusing of our services. We are now offering cognitive behavioral groups that focus on understanding partner substance use, criminal behaviors and creating plans for "change" with an increase in individual therapy services to support the co-occurring needs of our partners. We have only to look at our own efforts and evaluate our ability to increase the quantity and quality of our own services to hopefully address this need and positively impact and increase the partners' successes in the FACT and TrACT programs.

2a. Challenge - Partner Substance Abuse and increased incidence of partner behavioral issues
As a forensic behavioral health program, behavioral issues can be expected; however, these partner behaviors are occurring with increased frequency and aggression, as compared to partner behaviors from previous years in the programs. This increases the need for caution in providing services and the skills required for "crisis prevention and management" services. The team members along with the program leadership have developed new safety protocols and strategies for implementation. Substance use disorders play a significant role in the likely increased incidence of partners "acting out" behaviors, specifically, their use of derogatory statements (verbal abuse) and use of intimidation and threats of violence with team members is unfortunate, unacceptable and difficult to predict and prevent. Partner intoxication played a part in most of the incidents this past year. The need for safety on the job (both in the office and the community) has been compromised and requires increased vigilance by team members when working with partners, especially when responding to partner crises. Fortunately, the actual incidence of these partner behavioral issues occurring, although increasing in frequency, are an exception to the norm.
The program serves as representative payee for many of the partners that are in need of support to budget and manage their money so that the bills get paid and the partner has access to funds throughout the full month. This becomes a problem when partners under the influence come into the office, without prior notice given, demanding access to their money (that they have already spent or are not scheduled to receive). Partners can on occasion get verbally and physically (less frequent) escalated and aggressive to the point where their interactions with team members become volatile, unpredictable and on one occasion unmanageable. The team has been able to prevent or successfully manage a partner and their escalating behaviors through effective non-violent communication and teamwork. Requiring that the partner assertively escorting them from the building for the day. We have found that the threat of calling the police will usually diffuse a situation,

however, that is not always the case

2b. Strategies - The program leadership intends to begin addressing partner behavioral issues through the intake process and using an instrument(s) (based on partner tx history, needs and strengths) that will support team members in collecting an in-depth history on newly enrolled individuals as to increase our knowledge of these individuals while also supporting the development of a comprehensive and individualized treatment plan. We will also be introducing an instrument (such as the HCR -20) to assess each partners risk for violence/depression/suicide and recidivism. The program protocols and procedures will be updated to provide guidance on the implementation and use of these instruments. The leadership also plan to implement the use of an evidenced based strategy for identifying partner's criminogenic needs—anti-social personality, anti-social attitudes and values, anti-social associates, family dysfunction, poor self-control, poor problem-solving skills, substance abuse, and lack of employment/employment skills—and the 7 effective areas of programming called "domains"—employment /education domain, substance abuse domain, marital/family relations domain, associates and social interaction domain, community functioning domain, personal/emotional orientation domain and the attitude domain—to mitigate these needs of our mentally ill offender partners.

The team has identified certain partners that require 2 team members be present when providing services to these individuals. The FACT and TrACT programs need to be able to refer individuals with on-going behavioral issues that are beyond the capacity for the team to manage to a higher level of care where the process for referral is clear and possible (meaning that it is within the programs authority, when certain criteria are met, to refer an individual out to another program for services). The agency is committed to taking steps to ensure the safety of staff by securing the office building and parking lot. This FY we will be hiring a security company to monitor the office and the parking lot for the 2 days of the week (Tuesday and Thursday) when the partners are scheduled to come into the office to pick up checks/money from their sub-payee accounts. Having a security officer will help to instill a sense of safety back into the workplace. Our goal would be to have a plain clothed security officer who would be stationed in the front lobby with the receptionist. A security officer could support our Officer of the Day in redirecting partners who come to the office under the influence expecting to receive services or collect their money. Team members could work with the officer to offer any clinical support needed to assist a partner in leaving the office for the day. The officer could also participate in an intervention to support a partner in going to detox. The agency is also investing in the purchase of an electronic gate for the building parking lot as it will be extremely helpful in keeping the partners and others out of the parking lot so the team members can feel safe when going to their cars especially in the evening when it gets dark early.

3a. Challenge - Partner Substance Abuse and its indirect impact on the retention of team members ACT teams are known for increased turnover in staff when compared to traditional case management teams. FACT and TrACT are fast paced intensive programs that can prove too difficult for many individuals to succeed. It does take a unique skillset and commitment to self-care to be successful in this type of program. The teams have experienced high turnover especially in the peer specialist positions. In this past fiscal year, 14/15, the program had significant challenges in retaining team members in key leadership and direct service positions.

In reviewing the issues of recruitment and retention of program team members, there have been several known barriers that may contribute to the challenge of recruiting and keeping competent and dedicated employees. These may include:

- lack of compensation that is commensurate with the duties and responsibilities of the positions,

- the decreased availability of skilled and qualified professionals applying for open positions (especially for positions that, due to county contract expectations, require licensed or
- license eligible professionals) in the non-profit social services job market (which in turn increases the number of agencies in the county competing for the same small group of possible applicants),
- no COLA raises over the past two years from the county,
- The high acuity and complex needs (chronic substance abuse) of the partner population.

3b. Strategies - The program is painfully aware of the negative impact our inability to fill the vacant positions, especially on an ACT team, is having on our bottom line—contract expectations and program deliverables. Our need for a full team and increased performance to achieve program outcomes and we are certain of the agency and program leadership (and senior members of the team) met to discuss, develop and implement structural changes in the management structure of the program. This was a strategy that had been devised as a means for increasing the oversight and management of the many services provided daily. This, while ensuring the achievement of the program outcome expectations and while providing specificity and clarity to team members roles and responsibilities as stated in their individual job descriptions. The ever changing and increased needs of the partners and expectations from the contract has required transforming the program leadership to better support the team in providing program services. The salary structure for each of the program positions has been reviewed and the program and agency will be working with the county to support an increase in will be changed when the current budget is approved.

4. Program Curriculum implementation strategies
It is our belief that the implementation of the above strategies along with the implementation of the following program curriculum suggestions and The TrACT program leadership have been reaching out and soliciting support from other programs in and outside of the county and state with the goal of not having to reinvent the wheel in the form of information and ideas on addressing and overcoming the issues/challenges as stated in the previous section. The following is a brief summary of our strategies for a multi-pronged approach or course of actions to address and hopefully mitigate the challenges experienced by the program.

a) Comprehensive and measurable needs and strengths assessment: The program will be implementing the use of the ANSA (Adult Needs and Strengths Assessment) to increase the quality and depth of the partner assessment to include a thorough collection of risk information both historical and current and criminal information process treatment history information collected to include risk history and current assessment, criminal history and assessment of current needs.

b) Treatment Service: The program has have completed a thorough criminal justice mental health community based treatment literature and program review to procure ideas and examples of best practices and programs with the goal of adopting innovative and evidenced based treatment service and We have researched and reviewed many theoretical approaches to working with our particular population and will be implementing new or updated evidence based strategies and practices, that were alluded to in section 2b, which will increase the quantity, quality and effectiveness of clinical and recovery services provided to the partners in the group and individual therapy and rehabilitation modalities. These strategies and practices are rooted in the traditional mental health practice model of cognitive behavioral therapies however, are being presented by the different organizations in a modern form. One such potential new modality for open group services is a format and materials that were developed in part and offered by David Mee-Lee, MD. And members of the change companies (author of the ASAM instrument). The modality is based on the traditional mental health practice of cognitive behavioral therapies specifically as it has been developed to treat individuals

with histories of trauma, violence (perpetrators and victims), substance abuse and incarceration.

c) Alternative Payee Services: We have researched and found a new type of payee service that is available directly to our partners through telephone or email. The company is out of county and has no in person dealings with the partners. They have developed a clear, consistent and realistic money management and budgeting system for serving as a representative payee to consumers and will be able to support our program by serving as the representative payee for our more difficult and challenging partners. Thus, removing the financial responsibility variable from the dynamic of the professional partnership (partners and staff) in our attempt to work with and hold the individuals accountable for their actions and responsible for their treatment goals.

d) Changing program expectations and partner behaviors (continuation of 2b.): We have been researching and reviewing criminal justice mental health program literature and treatment resources on how best to provide interventions and ongoing support to our partner population in changing their behaviors and be able to stay focused in the program as to successfully meet their tx planning and life goals. We will be implementing new assessment and evaluation tools to be administered at enrollment and 6 months (TrACT) and annually (FACT) to ascertain 1) historical information, 2) risk through a comprehensive risk assessment and evaluation and 3) appropriate and partner specific goals to increase the efficacy of treatment while also increasing partner recovery efforts and the safe work and treatment environment.

Current FY 15/16 and Upcoming FY 16/17 planned program changes: The FACT and TrACT programs may be receiving an increase in funding this current FY and our programs may be expanding, increasing the programs' capacity both in the quality and quantity of services provided and the number of partners (still to be determined) who will be eligible for program services. This could enable the programs to increase the number of licensed or licensed eligible direct service provider's, to increase the diversity of services provided (including the increase in the program's capacity for the provision of 1 on 1 counseling). The programs increased capacity in the number of participants to be serve will help to end the long waiting list of persons and staff to serve an increased number of participants which will positively impact our relationship with our community provider's/referral sources that have been wanting to refer potential participants to the program. If the funding is increased the program will look to increase the full time equivalency for the provision of employment and education services (1. to ~2. FTE)—increasing program capacity for adhering to the fidelity scale for the IPS Supported employment model. We would also like to increase our nursing and will consider increasing from 1.4 to ~1.6 FTE and the psychiatry position (.35 to ~.50 FTE) or 20 hours of services per week.

The program leadership has been exploring the possibility of collaborating with a local health clinic with the intention to provide preliminary primary medical care on site. This will enable the program to increase partner access to primary care and support, especially the more medically fragile partners who have had difficulty in making staff supported scheduled appointments.

A. COMMUNITY SERVICES & SUPPORTS PROGRAM SUMMARIES

OESD 4A. Mobile Integrated Assessment Team for Older Adults

Program Description: Increase the access for homebound and/or isolated older adults who are experiencing difficulty accessing mental health services due to barriers associated with aging and mental health stigma. Work with First Responders and other community agencies to identify isolated older adults.

FY 14/15 Outcomes, Impact & Challenges: Developed new Peer Coach program component in which stable Mobile Mental Health (MMH) clients are matched with a new MMH client. The Peer Coaches and the Recipients both show improvement in self-efficacy and reduced sense of isolation. Strong partnership with Low Income Senior Housing complex that has dedicated ACBHCS apartments to insure residents with SMI were able to remain in their home. Increased use of clinical interns to increased language capacity.

The challenge of living with complex medical problems, loss and lack of affordable housing continue to be major stressors for older clients. We have experienced a significant amount of clients cancelling mental health services due to medical issues. Our Physician's Assistant moved out of area and the position is unfilled which is stretching our psychiatrist.

FY 15/16 Progress: Many of our clients are referred by First Responders (Fire/Code Enforcement) and have not been connected to mental health services in the past. Clients are often referred to our program in crisis. They are overwhelmed with issues of aging and are experiencing serious symptoms of mental illness. After intensive treatment with the Mobile Mental Health Team, the clients are stable but remain uncertain of their ability to manage the increased demands of aging. They are moving towards a time in life of interdependence. This year we will begin the implementation of a 'Step Down' level of services so that we can remain connected to the clients and monitor their well-being.

We continue to work closely with the Afghan Elderly Association to support older Afghans with PTSD/Anxiety symptoms. This year we are increasing the use of interns to develop a health promotion program that will include mental health screening.

Fully implement the Peer Coach program: We have trained 14 Peers, who are clients enrolled in our program, and they now all have a peer to support. This is a new program and this will be our first full year. We are assessing both the Coach and their peer on self-efficacy and isolation scales. This year we will collect and analyze the data.

We are in the process of obtaining a contract with Beacon Health to be in their Network to provide mental health services to individuals with mild to moderate symptoms. We feel this will support our Step Down program. We are also monitoring changes to MediCal reimbursement to see if Peer support will be reimbursed.

We are upgrading our Electronic Health Record in a move towards being paperless.

FY 16-17 Plans: Continue to develop appropriate services to impact the quality of life for Older Adults with mental health challenges. Establish stronger relationship with Health Plans and County Emergency Response systems. Move towards Electronic Health Records.

OESD 7. Mental Health Court Specialist (Court Advocacy Program)

Program Description: Increase access to community mental health services and reduce recidivism through advocacy and release planning for the chronic and severe mentally Ill population in the criminal justice system.

FY 14/15 Outcomes, Impact & Challenges: CAP staff has provided a variety of services for individuals involved in the criminal justice system with mental illness.

- CAP staff provides a presence in court rooms in Oakland, Hayward and as part time in Fremont and Pleasanton.
- They have been able to develop relationships with the Courts and the legal system and are often turned to for solutions and diversion/alternatives to incarceration.
- They work closely with the mental health providers in the jail so can help ensure clients receive treatment in a timely manner and assist with coordinating discharge planning which includes medications upon discharge.
- CAP staff successfully connects clients with appropriate community services as an alternative to incarceration.
- They provide education, consultation and support to community agencies and family members who are trying to navigate the legal system.
- Advocate for clients with attorneys and judges.
- Will follow clients while there criminal case is being resolved (for example may visit someone who has been sent to PES and work with PES, the community case manager and the Court to develop a diversion plan).

Although it is difficult to project the number of clients that will be served, CAP provides services to adults only. In FY 14-15 17 percent were TAY, and 6.5 percent were older adults from age 59 to 91 years old.

FY 15/16 Progress Report: In addition to the open cases CAP staff provides consultation, education, referrals and responds to calls from families/public defenders/D.A's/Judges, community providers on a daily basis. One of the challenges is documenting these services, the CAP program is continuing to explore methods for tracking large array of indirect services that are provided on a regular basis. CAP continues to work on ways to streamline documentation and ensure this is done so in a unified manner. CAP also hopes to have the addition of a working supervisor over the coming year for the CAP and Behavioral Health Court.

A. COMMUNITY SERVICES & SUPPORTS PROGRAM SUMMARIES

OESD 8. Juvenile Justice Transformation of the Guidance Clinic

Program Description: Provides in-depth assessment and treatment for youth in the juvenile justice system. Creates linkages to community based services and expands on-site treatment in Juvenile Hall.

FY 14/15 Outcomes, Impact & Challenges:

The Mental Health Specialist III was hired in December, 2013 and began working full time in the Transition Center helping youth successfully transition back to the community. From July 2014-June 2015 approximately 700 youth and their families have been seen in the Transition Center by the mental health clinician.

- Approximately 15% of those families refused services.
- 64% of the minors were already connected to services in the community.
- 37% of the minors were connected to services by the Transition Center mental health clinician.
- 25% were lost to follow-up (runaway, never returned calls, etc.)
- 26% went to placement.
- 19% had private insurance.

FY 15-16 Progress Report: The MHSIII will continue to see and link youth and families to services in the community.

- We also found that in the previous two years approximately 19% of the youth were discharged from JH with meds.
- At 30 days only about 14.5% went on to receive medication support in the community.
- At 60 days only 19 % receive medication support in the community.
- In the current fiscal year we will do two things to address this issue. First, the MHSIII set up an excel spread sheet to track all the youth who are started on meds in JH. The MHSIII will work with the youth and his/her family to ensure the following:
- That every youth who leaves, leaves with a valid prescription.
- The MHSIII will then work with the family to schedule an appointment with a psychiatrist in the community.
- The MHSIII will also follow-up with the youth and family at 30/60/90 days to track med compliance.

The clinic also is working on putting together a medication database that will ensure that the MHSIII in the Transition Center is aware as soon as a minor is placed on meds.

FY 16/17+ Plans:

- Over the next three years, the goal is to meet with 700 families per year for the next 3 years.
- The Transition Center mental health clinician will also continue to meet with 1 to 3 community providers per month to increase the network of service providers that youth will be connected to upon release.
- Over the next three years the goal is to boost the number of families who are connected to services from 14-19% to 40-50%.

As a clinic we will also work with our psychiatrist to look at what youth need to be placed on meds while in JH.

A. COMMUNITY SERVICES & SUPPORTS PROGRAM SUMMARIES

OESD 11. Crisis Stabilization Services – Willow Rock

Program Description: This strategy will provide crisis stabilization and acute care to youth ages 12-17 and their families, moving them towards a reduced level of care.

FY 14/15 Outcomes, Impact & Challenges: The Willow Rock Crisis Stabilization Unit provided 1586 assessments to adolescents (aged 12-17) in crisis. Of these youth, 889% were brought to the CSU on an involuntary civil commitment hold (WIC 5585), while 11% were voluntary walk-up clients. Based on the multidisciplinary, comprehensive assessment of the youth's needs, 48% of youth assessed at the CSU were diverted from hospitalization.

When asked how welcome staff at the CSU made youth feel, satisfaction surveys of youth served in the CSU show a score of 3.84 out of 4. One youth stated that while at the CSU they felt "comfort in a time of need", while another commented that their time at the CSU "helped [me] find the root of [my] crisis and how to cope with it."

Willow Rock continues to impact the community by participating in for Alameda County police officers, covering the topic of youth mental health issues and providing tours of the facility. In addition, Willow Rock and its staff support community awareness by providing tours for school district personnel, hospital staff, and other community agencies, and engaging in collaborative efforts such as the Chief Mental Health Advisory Board for the Oakland Police Department.

FY 15/16 Progress Report: While we cannot predict the clients to be served in the future due to the nature of the crisis work at the CSU, it is predicted that we will continue to see slight growth each year in the number of youth served by the program.

Approximately 37% of youth assessed at the CSU during fiscal year 14/15 were TAY youth (aged 16 and 17). It is estimated that as similar percentage of TAY youth will be served this year. No older adults will be served as the CSU only serves ages 12-17.

FY 16/17+ Plans: We will continue to monitor and evaluate the program as well as the acuity and needs of the youth served in order to adjust to an ever changing population as indicated.

OESD 17. Residential Treatment for Co-Occurring Disorders

Program Description: Provides housing, medication assessment, evaluation, education, support and monitoring to individuals with co-occurring mental health and substance abuse disorders in alcohol and drug treatment settings throughout the county.

FY 14-15 Outcomes, Impact & Challenges:

Cronin House is a licensed and certified co-occurring capable residential treatment facility serving both men and women. 100% of our clients are required to have co-occurring mental health and substance abuse diagnoses. We served 211 clients in FY 2014-2015. 80% of our clients are homeless. Cronin House provided crisis intervention and stabilization, education, process and skills training groups in addition to supportive case management and linkage services to clients in early recovery from mental health and substance abuse issues. In addition, we provided on site Dual Recovery groups, a Family Education Group and therapy to family members and couples. We focused on developing client's strengths, peer connections and understanding of the connection between their mental health and substance abuse. Clients also have an opportunity to develop leadership and peer support skills on Client Council and be a Big Brother or Sister to a new client in the program. When clients come to Cronin, there is an assumption they have experienced intense trauma that they may or may not be able to acknowledge while at Cronin. Operating from this lens, we offer opportunities to identify and practice coping skills to help clients manage trauma, substance abuse and other triggers that have led to maladaptive behaviors in the past. Cronin House continued its focus on providing access to healthcare for the increasing number of clients without a psychiatrist, primary care physician and/or dentist. Cronin House offered service for clients on methadone maintenance and in partnership with East Bay Community Recovery Project (EBCRP) provided HIV and Hepatitis C education on site twice a month. Peers Envisioning and Engaging in Recovery (PEERS) provided quarterly day long Wellness Recovery Action Plan trainings for the clients. Chrysalis is a 16 bed licensed co-occurring capable residential treatment facility serving women 18 years and older. The maximum stay is six months. 100% of our clients are required to have co-occurring mental health and substance abuse issues. Chrysalis is a tobacco free program offering smoking cessation education groups, nicotine patches and gum to assist with withdrawals as well as referrals to 1-800-NO-BUTTS. The purpose of this community based program is to prevent hospitalization, promote habilitation and rehabilitation and successful independent living in the community for individuals who have a diagnosed significant mental illness and whose use of drugs or alcohol exacerbate or complicate the illness and increase the risk of unhealthy behaviors and lack of community success. On average approximately seven intakes a month are conducted at Chrysalis and approximately 86 clients every year are being served of which approximately 83% are homeless. Chrysalis operates on the principal of social rehabilitation utilizing co-occurring substance abuse and mental health treatment best practices. Treatment is client centered and strengths based thus placing major emphasis on the involvement of the clients in the determination of their own treatment and rehabilitation plans. Cognitive Behavioral, Motivational Interviewing, Seeking Safety and other programs form the foundation of our behavioral interventions. Staff support and witness clients self-administer their medications, learn how to monitor, dispense and be aware when they need refills or a Doctor's consult. The goal is to assist the client to be as medically-literate as possible, gain or enhance her capability to be responsible for her own medications, and engage in constructive dialogue about medications with her own physician, pharmacist or other medical personnel. Onsite AA and NA meetings are offered. Family education/support groups are conducted and an active Resident Council is developed in order to be the voice of the community. Chrysalis in partnership with East Bay Community Recovery Project (EBCRP) provides HIV and Hepatitis C education and testing on site twice a week. EBCRP also provides education and confidentiality

training to Chrysalis staff.

Cronin House is a licensed and certified co-occurring capable residential treatment facility serving both men and women. 100% of our clients are required to have co-occurring mental health and substance abuse diagnoses. 75%-80% of our clients are homeless.

The level of mental health disability and medical complications has increased in our clients over recent years. The majority of our clients have complex mental health issues including multiple traumas and PTSD symptoms. Because our clients are in early recovery and have often been homeless, they have many unmet emotional and physical needs. We are challenged to find new avenues to help our clients with their psychiatric, medical and dental needs. We struggle to provide the needed transportation to psychiatric, medical, and dental appointments. To serve our more severely disabled population, we need highly skilled, well trained staff, who understand mental illness, trauma and addiction. Cronin House provides intensive training in order to support our staff as they serve our clients in a uniquely challenging environment.

Services provided by Cronin House include crisis intervention and stabilization, education, process and skills training groups in addition to supportive case management and linkage services to clients in early recovery from mental health and substance abuse issues. We also provide medication management on site Dual Recovery groups, a Family Education Group and therapy to family members and couples. We focused on developing client's strengths, peer connections and understanding of the connection between their mental health and substance abuse. This year, we will be implementing Cognitive Behavioral Therapy Groups (CBT), an evidenced based practice, with the intention of training the clients to use CBT techniques to help them with their mental health and substance related symptoms. In the past, we have incorporated CBT into our program, specifically in the Co-occurring Disorders Group, Relapse Prevention Group and individual therapy. The new CBT Group will train clients using CBT vocabulary and provide opportunities to practice and develop individual techniques.

Chrysalis is a licensed and certified co-occurring capable residential treatment facility serving women 18 years and older. The maximum stay is six months. 100% of our clients are required to have co-occurring mental health and substance abuse issues. Chrysalis is a tobacco free program offering smoking cessation education groups, nicotine patches and gum to assist with withdrawals as well as referrals to 1-800-NO-BUTTS. The purpose of this community based program is to prevent hospitalization, promote habilitation and rehabilitation and successful independent living in the community for individuals who have a diagnosed significant mental illness and whose use of drugs or alcohol exacerbate or complicate the illness and increase the risk of unhealthy behaviors and lack of community success. On average 86 clients every year are being served of which approximately 83% are homeless. Chrysalis operates on the principal of social rehabilitation utilizing co-occurring substance abuse and mental health treatment best practices. Treatment is client centered and strengths based thus placing major emphasis on the involvement of the clients in the determination of their own treatment and rehabilitation plans. Cognitive Behavioral, Motivational Interviewing, Seeking Safety and other programs form the foundation of our behavioral interventions. Staff support and witness clients self-administer their medications, learn how to monitor, dispense and be aware when they need refills or a Doctor's consult. The goal is to assist the client to be as medically-literate as possible, gain or enhance her capability to be responsible for her own medications, and engage in constructive dialogue about medications with her own physician, pharmacist or other medical personnel. Onsite AA and NA meetings are offered. Family education/support groups are conducted and an active Resident Council is developed in order to be the voice of the community. Chrysalis in partnership with East Bay Community Recovery Project

(EBCRP) provides HIV and Hepatitis C education and testing on site twice a week. EBCRP also provides education and confidentiality training to Chrysalis staff.

Chrysalis is a licensed and certified co-occurring capable residential treatment facility serving both men and women. 100% of our clients are required to have co-occurring mental health and substance abuse diagnoses. 75%-80% of our clients are homeless.

The level of mental health disability and medical complications has increased in our clients over recent years. The majority of our clients have complex mental health issues including multiple traumas and PTSD symptoms. Because our clients are in early recovery and have often been homeless, they have many unmet emotional and physical needs. We are challenged to find new avenues to help our clients with their psychiatric, medical and dental needs. We struggle to provide the needed transportation to psychiatric, medical, and dental appointments. To serve our more severely disabled population, we need highly skilled, well trained staff, who understand mental illness, trauma and addiction. Chrysalis provides intensive training in order to support our staff as they serve our clients in a uniquely challenging environment. Services provided by Chrysalis include crisis intervention and stabilization, education, process and skills training groups in addition to supportive case management and linkage services to clients in early recovery from mental health and substance abuse issues. We also provide medication management on site Dual Recovery groups, a Family Education Group and therapy to family members and couples. We focused on developing client's strengths, peer connections and understanding of the connection between their mental health and substance abuse. This year, we will be implementing Cognitive Behavioral Therapy Groups (CBT), an evidenced based practice, with the intention of training the clients to use CBT techniques to help them with their mental health and substance related symptoms. In the past, we have incorporated CBT into our program, specifically in the Co-occurring Disorders Group, Relapse Prevention Group and individual therapy. The new CBT Group will train clients using CBT vocabulary and provide opportunities to practice and develop individual techniques.

FY 15/16 and 16/17 Plans:

- Cronin House is presently in the process of identifying staff training and logistical changes necessary to develop specific program services for LBGTQQI2S clients. We have attended trainings and have updated our intake form to reflect variations in gender identity and sexual orientation.
- Cronin provides a unique program serving men and women with both severe mental health and substance use disorders. We are experiencing increasingly time consuming requirements for staff to case manage the complex medical and psychiatric needs of our clients as described above. Perhaps even more significant is our difficulty in hiring and retaining qualified staff to work in our program. The barrier is inadequate funding to enable us to pay adequately skilled staff to provide the services needed by our clients. We plan to meet with BHCS staff to discuss specific strategies to mitigate these barriers.
- Chrysalis, in our efforts to more effectively serve LGBTQQIS2S clients has consulted with the Transgender Law Center, Gender Spectrum, and the Pacific Center this past year. Chrysalis' Clinical and Milieu Counselors have attended both external and internal training to improve our service to the LGBTQQIS2S community as well. Chrysalis' Intake Forms have been modified to include Gender Identity and Sexual Orientation.
- Chrysalis provides a unique program serving women with both severe mental health and substance use disorders. We are experiencing increasingly time consuming requirements for staff to case manage the complex medical and psychiatric needs of our clients as described above. Perhaps even more significant is our difficulty in hiring and retaining qualified staff to work in our program. The barrier is inadequate funding to enable us to pay adequately skilled staff to provide the services needed by our clients. We plan to meet with BHCS staff to discuss specific strategies to mitigate these barriers.

OESD 19. Low Income Health Plan Pilot (HPAC)

Program Description: Broad array of services to provide increased access of consumers of the system to primary care services.

FY 14/15 Outcomes, Impact & Challenges: As a result of our services we provided psychiatric services to clients with serious mental health issues. We reduced incarceration, psychiatric hospitalizations, and mental health disparities across Alameda County. We did this through; Outreach, Education and Consultation 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 practicable.

Challenges include shifting to only serving moderate to severe clients. Our strategies are to shift our services to accommodate the severity of the clients using the modality of mental health recovery within a medication management model.

FY 15/16 Progress: We plan on serving approximately 3300 total clients, 1100, TAY youth, 270 older adults, 250 child clients. Continued Outreach, Education and Consultation to families, employers, primary care health care providers, and others is critical to helping everyone recognize the early signs of potentially severe and disabling mental illness. These are all preventive methods in order to reduce the need for higher levels of care. Access and linkage to medically necessary care

as early in the onset of these conditions as practicable is also important to the people we serve and to our community as a whole. Further outreach, education and consultation is needed due to the large volumes of clients we serve within Pathways to Wellness. We will provide psycho-education to guide clients on recognizing their early signs of potentially severe and disabling mental illness. Funding is needed improve immediate access to our services and to avoid higher levels of care when appropriate. This includes transportation costs and funding for more staff to process incoming referrals, enroll individuals and to check eligibility. We believe that it is important to add on paid peers with lived experience into our model of care. Lastly, we are seeking funding to support Family Partner integration which will implement peer counselors, family advocates, and family support counselors to increase the consumers' wellness access and reliance on their self-built communities.

OESD 20. Individual Placement Support / Supported Employment (Alameda County IPS)

Program Description: Alameda County Behavioral Health Care Services, in conjunction with the California Department of Rehabilitation, has embarked on a long-term plan to implement Individual Placement and Supported Employment (IPS). This evidence-based practice assists adult and transition-age youth consumers with finding and maintaining competitive jobs in the community available to people with and without disabilities. Engagement, job development, placement, and job follow-along supports are the core program elements of this approach.

The following key features illustrate some of the essential aspects of Alameda County IPS:

1. No consumer is excluded from program access or participation due to diagnosis, presence of symptoms, substance abuse, housing status, personal presentation, etc. Desire to get a competitive job is the criterion for services, because motivation to work is a strong predictor of success.
2. Upon entry into IPS services, consumers receive direct assistance with making employer contact quickly, usually within 30 days. There are no requirements for vocational testing, work samples, employment groups or other pre-vocational activities.
3. Employment specialists make frequent, in-person employer contact and build employer relationships based on the consumer's preferences in order to make a good job match.
4. Vocational services are individualized to fit the needs and preferences of each consumer. Individualized job search and job follow-along plans reflect each person's unique interests, goals and needs.
5. Competitive jobs are the goal, and transitional and/or sheltered employment is not utilized in order to avoid delaying progress to achieve competitive employment.
6. Once a consumer obtains a job, the follow-along services are provided continuously until the job is stable or people no longer request services. Employment specialists provide a wide-range of job coaching and job supports to support a person's success.
7. Vocational services are integrated closely with mental health services in order to ensure IPS program success. Employment specialists meet weekly with mental health teams (case managers, personal service coordinators, peer specialists, and/or psychiatrists) to share information, collaborate, and plan services.
8. Ongoing quality improvement efforts focus on building on program and staff strengths to ensure that over time program outcomes for jobs is enhanced. The Supported Employment Fidelity Scale is utilized for quality improvement guidance.

A. COMMUNITY SERVICES & SUPPORTS PROGRAM SUMMARIES

These services are available to people with serious mental illness that are part of ACBHCS adult service teams, Full-Service Partnerships, Level 1 specialty providers, and Level 1 Transitional Age Youth (TAY) Programs.

FY 14/15 Outcomes, Impact & Challenges: Alameda County IPS served 276 consumers, 124 of whom worked competitive jobs, which equals a competitive employment rate of 45%. We secured 125 competitive job placements for people, including positions in the administrative, retail, food service, warehouse, transportation, and education sectors. Competitive employment rate percentage is the number of clients in the IPS program who worked a competitive job in the community divided by the total number of people in the IPS program. Benchmarks set by the Dartmouth IPS Collaborative include 30% minimal standard, 40% good standard, and 50% exemplary standard.

This year we increased the integration of vocational and mental health services on County-run case management teams by moving staff offices near their mental health teammates, requiring staff attendance at weekly mental health team meetings, and promoting team collaboration.

Alameda County IPS also provided ongoing, intensive consultation and technical assistance to Fred Finch Youth Center, Bay Area Community Services, and Building Opportunities for Self-Sufficiency's IPS programs this year. Together, these programs served 143 people and helped 73 people obtain competitive jobs.

In November 2014, we hosted a one-day IPS Learning Conference that was attended by 150 local and regional mental health and vocational leaders. The Learning Conference showcased our IPS programs' success and encouraged other agencies to adopt the practice.

FY 15/16 Progress Report: Alameda County IPS plans to directly assist 300 adult and TAY consumers with obtaining and maintaining competitive jobs that fit their preferences.

Planned changes:

- Achieve good fidelity to the model in this year's fidelity review.
- Implement Supported Education services for consumers who want help to go to school or training.
- Streamline business processes to increase efficiency, including making all vocational documentation electronic and user-friendly.
- Host a second IPS Learning Conference to highlight success and increase consensus.
- Continue to provide technical assistance and leadership for vocational services in Alameda County. We will help Full Service Partnerships and Assertive Community Treatment Programs start IPS by the end of the year, along with providing continued assistance to existing IPS programs.

FY 16/17+ Plans: Alameda County IPS plans to directly assist 320 adult and TAY consumers with obtaining and maintaining competitive jobs that fit their preferences.

Planned changes:

- Continue to look for opportunities to increase fidelity to the IPS model.
- Continue to provide technical assistance to agencies providing IPS services.
- Assessing system-wide implementation of IPS and determining if additional training resources are necessary.

A. COMMUNITY SERVICES & SUPPORTS PROGRAM SUMMARIES

OESD 21. Housing Services Office

Program Description: MHSA funds were used to create the Housing Services Office with the following goals in mind for the entire mental health services network and the people it serves:

1. Increase the availability of a range of affordable housing options with appropriate supportive services so that individuals can "choose", "get", and "keep" their preferred type of housing arrangement;
2. Minimize the time individuals 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 BHCS target populations;
4. Provide centralized information and resources related to housing for BHCS 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 through active participation in the EveryOne Home plan implementation.

For current FY 15-16 Progress Report:

MHSA Housing Development Fund	State and local MHSA dollars were set aside to fund parts of affordable housing development costs – capital (land/building), operations, and services. One-time investments result in dedicated affordable housing unit set-asides for a minimum of 20 years. The funds have helped support 23 housing projects with a total of 151 MHSA units. Combined these projects resulted in 1,146 affordable housing units in the County.
Housing Support Program (HSP) formerly known as the Supplemental Rate Program (SRP)	HSP provides a monthly "patch" or "subsidy" payment for BHCS referred and approved clients to 14 operators of licensed board and care homes (6 Residential Care Facilities for the Elderly and 11 Adult Residential Facilities – 275 beds). Referrals into these beds prioritized for individuals being discharged from state hospitals, Gladman, Villa Fairmount, and Morton Bakar.
BHCS EveryOne Home Housing Assistance Revolving Fund	A Housing Services Office managed revolving housing assistance fund that helps householdsreceiving BHCS services address financial barriers to obtaining or retaining housing. The fund works as a homelessness prevention and re-housing fund for BHCS consumers. Service providers must apply in partnership with their clients and landlords. Information on the program is at http://www.acbhcs.org/Housing/housing_loans.htm

Housing CHOICES program	Provides a 3-year flat-rate rental assistance subsidy for participants in the CHOICES program. Some participants are eligible for a Section 8 voucher at the end of the 3-year period. The Housing Authority of the County of Alameda (HACA) operates this program in collaboration with the Bonita House CHOICES team. The CHOICES program is coming to an end and these funds are gradually being redirected to provide project-based housing subsidies and other housing supports for the system as a whole. We will be working to retain the relationship with HACA and the Section 8 voucher resource for BHCS consumers.
Full Service Partnership MHSA Housing dollars	These funds are embedded in Full Service Partnership (FSP) budgets. In addition to these MHSA funds, there is *$2,283,025 worth of HUD housing subsidy funds* connected with MHSA funded service programs.
Emergency/ Interim Housing	MHSA funds are used to support the operation of two BOSS emergency housing programs each with a bed capacity of 24 for a total of 48 beds – Casa Maria and South County Homeless Project. MHSA funding for Casa Maria includes $311,194/year for BOSS operational costs and approximately $192,000/year to lease the space form St. Vincent de Paul = $503,194. South County Homeless Project is operated via a contract with BOSS for $475,987/year. This program is operated out of a county-owned property. SAMHSA Mental Health Block Grant funding is used to fund additional emergency housing capacity at East Oakland Community Project and the BOSS Berkeley shelter.
Housing Navigation Services	*BACS North County Housing Connect* - $387,600/year of MHSA funds + Medicaid revenue – focused on helping homeless individuals with serious mental health issues obtain and retain permanent housing. *Bonita House CHOICES Program* -$435,540- housing specialists that help service team clients participating in CHOICES to find and maintain permanent housing and utilize the CHOICES housing subsidy. This program is evolving to have housing specialists focused on using a variety of housing subsidy resources to help homeless clients with serious mental illness obtain and retain permanent housing. NOTE**:** BOSS and St. Mary's Center operate housing navigation programs for homeless persons with serious mental health issues that are funded by SAMHSA dollars.

Permanent Supportive Housing Services	*BACS Supported Independent Living* - $39,000 (MHSA from housing development reserve) + Medi-Cal revenue - provides supportive services linked to BACS permanent housing sites. *BOSS Housing Services Team* - $229,148 – provides supportive services to individuals living in BOSS permanent housing sites or in BOSS-linked HUD rental assistance units for homeless persons. *LifeLong Medical Care* – OPRI - $44,061 from housing development fund reserve + $124,017 and City of Oakland funding to support services in HUD funded permanent supportive housing sites in Oakland. Total MHSA funds for this = $168,078. NOTE: Nearly all of the permanent affordable housing sites with dedicated MHSA units have on-site services included in their operating costs. These costs are not reflected here and are covered by a mixture of funding sources including some of the original MHSA dollars invested in each property.
Alameda County Housing and Community Development – Housing Partnership Agreement	$54,000/year – for managing HUD rental assistance grants linked with BHCS programs; $38,115/year – for matching funding for a HUD supportive services grant known as RISE; $60,000/year – annual contribution to EveryOne Home base operating budget; $50,000/year – for Eden Information and Referral to operate a housing search website and related phone service – www.achousingchoices.org ; $100,000/year – for audits/quality assurance of MHSA housing sites and special housing projects.

For upcoming FY16-17 Plans:

More coordinated management of resources to support community living facilities including licensed board and care homes.

OESD 22. Wellness Centers

Program Description: The Wellness Centers are designed as an exit strategy for participants who are on intensive case management teams and full service partnerships in Alameda County as they develop their wellness and recovery plans and link with natural and community supports. The main program goals are focused on helping individuals create a fuller life in the community without the need of more intensive mental health services. Each individual is supported in developing their own recovery goals for wellness and community living. The monthly team meetings focus on the participant's successes in achieving progress in the 8 domains of wellness in their life. This is reviewed in these meetings together with a Case Manager, a Peer Counselor, an Employment Coordinator, a Psychiatrist and any one in the participant's community who can help them to achieve their goals that are developed out of the team meeting format.

The main interventions are the following:

1. Team meetings, which occur monthly as needed to develop action steps based on needs to help individuals transition from center based supports to community based supports;
2. Classes and Workshops based on the domains of wellness to assist individuals in learning the skills necessary to transition to community services
3. Employment Services with the Individual Placement and Support (IPS) model to assist individuals in attaining gainful employment in the jobs of their choice
4. Psychiatric support from a wellness and recovery oriented psychiatrist to assist the individual's to transition to community based care
5. Support individuals to attain and achieve independent living in permanent housing places of their choosing.

FY 14/15 Outcomes, Impact and Challenges: During the first half of the fiscal year the BACS Wellness Centers provided transitional community-based case management designed as an exit strategy for participants on service teams and full service partnerships in Alameda County. The main program goals were to help individuals create a fuller life in the community without the need for more intensive mental health services. Monthly team meetings helped participants to focus on 8 domains of wellness and recovery along with their case manager, peer counselor, employment specialist, and psychiatrist. During the first half of the year the BACS Wellness Centers provided services for 191 consumers, where 81% of all graduates of the program experienced no hospitalization for psychiatric reasons in the year following their discharge. In the second half of FY 14-15, BACS in collaboration with BHCS committed to transforming the Wellness Centers into barrier-free peer run community centers for all consumers of mental health services. The Wellness Centers increased groups, classes, and circles to 3-5 times daily, and increased operating hours with limited Saturday and Holiday services. By the end of the fiscal year the Wellness Centers had increased utilization by more than double by providing services to 394 unique clients in June 2015. Notable community contributions include:

- Wellness Centers were open for usage by any behavioral health participant at any level of care.
- Consumers were able to access Medications only psychiatry at all the Wellness Centers, or continue with their psychiatrist with their service teams or Level III centers.
- Consumers had the freedom to partake in the services of their choosing for as long as they

would like to participate. There are no time restrictions for services.
- The Wellness Centers continue to operate a full complement of wellness and recovery skill building groups, classes, and circles.
- The centers increased their staffing levels with individuals with lived experience.
- A 90 person triage/transitional case management program is open to participants who are in need of short-term targeted case management to help stabilize their lives.
- Participants receive supported employment services with Employment Counselors that practice Individual Placement and Support (IPS), an evidence based practice to help them find and maintain competitive employment in the community.

The transition from providing primarily transitional community-based case management to a more open consumer-led community center was a welcomed opportunity for BACS. Primary challenges included ramp up for new staffing levels for the consumer-led programming as the organization hired 14 Peer Counselors between November 2014 and January 2015. Peer Counselors were given training and individual support learning to provide milieu and group services, one on one counseling, and non-violent crisis de-escalation. BACS, with the support of BHCS, engaged in an information and marketing campaign to draw consumers to the newly reformatted Wellness Centers. BACS leadership and Peer Counselors presented for Service Teams, Full Service Partnerships and ACT teams, Level III clinics, SRP operators and residents, local SRO operators and residents, the ACCESS team, Crisis Response Program, Transition-aged youth Assessment Team, Alameda County Probation, Villa Fairmont, John George Hospital, and various community-based organizations, and faith-based organizations.

FY 15/16 Progress: BACS has committed to providing services to 400 unique TAY, Adult, and Older Adult consumers at the Wellness Centers for Fiscal Year 15-16. It is the agency's goal to surpass this count and to provide barrier free consumer-led behavioral health services for as many interested participants as possible in Alameda County.

BACS Wellness Centers have committed to fostering an inclusive horizontal community building structure to garner peer led management of the programming at the centers, thereby acting as cooperatively organized environments. During this year BACS will be transitioning to call the centers Wellness Co-Ops to capture the spirit of the primary partnerships and programming of the sites. The Wellness Co-Ops have recently begun to provide daily meals across the four sites, including lite breakfast and cooperatively prepared lunch to all participants. BACS is currently partnering with the POCC, Bonita House, Narcotics Anonymous, Family Education and Resource Center, NAMI, and BHCS to provide and expand joint classes and groups at the Co-Ops. BACS will continue to employ a guerilla marketing strategy to bring consumers to the Co-Ops that will include transportation arrangement and "Wellness Co-Op without Walls" where Peer Counselors facilitate groups with consumers in the community. BACS is currently implementing an evidence-based practice at the Co-Ops with the short term targeted case management team with a peer feedback tool called Partners for Change Outcomes Management System (PCOMS).

FY 16/17 Plans: BACS has committed to providing services to 600 unique TAY, Adult, and Older Adult consumers at the Wellness Co-Ops for Fiscal Year 16-17. It is the agency's goal to surpass this count and to provide barrier free consumer-led behavioral health services for as many interested participants as possible in Alameda County.

The agency will continue to explore opportunities to expand services and increase utilization at the Wellness Co-Ops by being attentive to the consumer community. BACS will continue to look to draw in evidence-based practices to augment services and will look to expand and grow partnerships in the community to provide new, interesting, and rehabilitative services to the Wellness Co-Ops.

B. PREVENTION & EARLY INVERVENTION PROGRAM SUMMARIES

Alameda County has implemented a variety of Prevention and Early Intervention (PEI) programs for the purpose of "preventing mental illness from becoming severe and disabling and improving timely access for underserved populations."[1]

It's the intention of all PEI programs to emphasize strategies for the goal of reducing negative outcomes that may result from untreated mental illness: suicide, incarcerations, school failure or dropout, unemployment, prolonged suffering, homelessness, and removal of children from their homes.

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 schools, justice systems, primary care and a wide range of social services and community groups. In addition to these partnerships, the county has also placed these preventative and early intervention services in convenient places where people go for other routine activities. The MHSA specifies that all funded PEI Programs must include:

- **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 practicable;

- **Reduction in stigma and discrimination** associated with either being diagnosed with a mental illness or seeking mental health services and reduction in discrimination against people with mental illness (MHSA, Section 4, Welfare and Institutions Code (WIC) § 5840(b)).

1 Proposition 63: Mental Health Services Act 2004
2 MHSOAC PEI Fact Sheet, December 2012

B. PREVENTION & EARLY INVERVENTION PROGRAM SUMMARIES

MENTAL HEALTH CONSULTATION PROGRAMS

PEI 1.A Mental Health Consultation in Preschool

Currently the funds for this program are being used as part of the match funding for a SAMHSA grant to develop a system of care for the 0-5 community. This program is called **Early Connections**, an Initiative to strengthen services and supports for children 0-5 and their families.

For previous FY 14-15	For upcoming 15-16, FY16-17
Family Partner Integration Strategy: Family Partners are parents with lived experience in utilizing the early childhood system of care services and supports for their own children. Family Partners practice and integrate family driven care principles and practices which has shown shorter lengths of treatment and improved outcomes for children and youth. www.ffcmh.org (National Federation of Families for Children's Mental Health) **Outcomes:** • Increased family engagement through utilization of Family Partners. • Increased family knowledge regarding community resources. • Decreased parent stress in caring for a child with social, emotional and behavioral concerns. • Increase in child's strengths, such as resilience and stronger parent/child attachment. • Improved child social/emotional behavioral functioning. • Increased family leadership skills. **Impact:** • 192 young children and their families were served by Family Partners. • Family Partners provided services in English, Spanish, Chinese and Vietnamese. • Early Connections developed and implemented a series of trainings for Family Partners and the early childhood mental health providers, along with ongoing technical assistance provided in monthly learning communities for each group. • Qualitative evaluation of the integration of Family Partners in early childhood mental health agencies was completed.	**Family Partner Integration Strategy:** • Maintain or exceed the 192 children and families that were served in FY 14-15 and 15-16. • Completion and Implementation of the Family Partner Integration Training Curriculum. • Continue to provide support and technical assistance to community-based organizations with the goals of retention of current Family Partners and expansion/increased number of Family Partner hires. **Parent Café Peer to Peer Education and Support Groups:** • Maintain or exceed the 45 parents of children, ages birth-5, served by Parent Café groups. • Provide continued support and technical assistance to community-based organizations in the training and development of parent

Challenges:

- Agencies who employ and supervise the Family Partners have not made structural changes to their programs to accommodate the role and needs of Family Partners – the goal is integration of Family Partners at an agency and systems level.

Strategies to Mitigate Challenges:

- Early Connections established Family Partner and Family Partner Supervisor Learning Communities that meet on a monthly basis. Facilitation and technical assistance are provided at these Learning Communities to more fully understand the steps to integration of Family Partners towards goal of sustainability.
- Integration of Family Partners is addressed is frequently discussed at executive administration meetings towards the goal of advocacy for integration across the system of care.
- Family Partner Integration Tool Kit and Family Partner Integration Training Curriculum are in final stages of completion and will help mitigate challenges.

Parent Café Peer to Peer Education and Support Groups:

Parent Café is a peer to peer group that is facilitated by parents for parents. The focus is on child development and parenting of young children, ages birth-five.
Parent Café is informed by the Strengthening Families framework that integrates five protective factors that are key to prevention and early intervention.
www.strengtheningfamilies.net

Outcomes:

- Increased confidence in parenting skills.
- Increased knowledge on child development, including social/emotional development of young children.
- Increased confidence in navigating the early childhood system of care for young children.
- Increased confidence in leadership skills - parents are trained to facilitate the groups.
- Expansion of Parent Café groups in the Asian community. Asian Community Mental Health has convened groups in Chinese with the families they serve.
- leaders to convene the groups.
- Continued support of development of Parent Café groups in threshold languages.

Mental Health Consultation (MHC) in Early Care and Education:

- In collaboration with partner agencies and parents, complete a Mental Health Consultation Standards of Practice document that will inform consistent services.
- In collaboration with partner agencies and parents, develop infrastructure to support the MHC standards of practice. Infrastructure will include logic model or theory of change, training on MHC, recommendations regarding supervision of MHC and outcomes/ evaluation plans.
- Develop and implement a Request for Proposal to early childhood community seeking agencies to implement the MHC Standards of Practice, along with infrastructure components.
- Collect data on children, parents and teachers served by these awarded agencies.

Impact:

- 45 parents of children, ages birth-5, participated in Parent Café Peer to Peer Education and Support groups.

Challenges:

- Parent Café groups can be expensive to convene in the community given need for child care, staffing and food.

Strategies to Mitigate Challenges:

- Community based organizations have formed resource groups within their agencies to tap into resources. They have also partnered with family run organizations to develop these resources.

Mental Health Consultation in Early Care and Education (Infant/Toddler and Preschool Programs)

Mental health consultation in early care and education is a promising prevention and early intervention service – see www.ecmhc.org

- Began the process of identification and documentation of mental health consultation standards of practice in Alameda with the goal of establishing consistent practices county-wide.

B. PREVENTION & EARLY INVERVENTION PROGRAM SUMMARIES

PEI 1. B/C School-based Mental Health Consultation Programs

School-Based Mental Health (SBMH) consultation currently serves 16 out of the 18 Alameda County school districts, and provides a variety of consultation services including: Child Specific Consultation; General Consultation; Trainings/Workshops; Transition Planning; Service Coordination, and Supports.

SBMH Consultation Services must: involve building the capacity of schools to address the social, emotional, and behavioral learning needs of students; promote a school climate that identifies and addresses student mental health needs and is supportive of students at risk for serious mental health issues; develop collaborative partnerships with teachers, staff, parents, and other providers to create school environments that promote healthy, social emotional development; help make social-emotional learning supports available to all students; and facilitate effective problem-solving among adults and students.

For previous FY 14-15	For upcoming FY 15-16, FY16-17
For FY 13/14 the County, in partnership with the Alameda County School Districts, has developed an evaluation framework and has started a data collection process to determine a number of identified results including: 1) children are physically, socially and emotionally healthy; 2) children succeed academically; 3) environments are safe supportive and stable; 4) families are supported and supportive and 5) Systems are integrated and care is coordinated and equitable. As data is gathered analyzed more information will be shared. Targeted served 8,000 children, youth and families	No planned changes Projected people served: **FY 15/16:** 8,500 children, youth and families **FY 16/17:** 9,000 children youth and families

B. PREVENTION & EARLY INVERVENTION PROGRAM SUMMARIES

PEI 3.C Mental Health-Primary Care Integration for Older Adults at ERs (Geriatric Assessment and Response Team (GART) Program

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. The GART Program staffing includes a multi-disciplinary team and support staff.

For previous FY 14-15	For FY 15-16, FY 16-17
OUTCOMES: • GART became fully staffed and trained in Older Adult services. • Client enrollment has increased 250% from FY 11/12 to FY 12/13, 48% from FY 12/13 to FY 13/14, 39% from FY 13/14 to FY 14/15 for an overall increase from GART's inception of 617%. • For FY 14/15 of the 39 discharged clients 17 clients reached or partially reached their treatment goal(s) • Service hours provided for FY 14/15, 16% was Case Management, 27% was Medication Support and 62% was Mental Health. • 100% of clients who completed the "GART Client Evaluation" expressed satisfaction with the services they received at GART. Current Evaluations Responses include: "I am very satisfied with your services" "You helped me solve many of my problems" "Thank you for the special home visit services" "Wish more folks knew about this great Alameda County Program" "Thank you so much for being there"	Projected clients served: **FY 15-16:** 55 **FY 16-17:** 69

B. PREVENTION & EARLY INVERVENTION PROGRAM SUMMARIES

PEI 4. Stigma and Discrimination Reduction Campaign Program Description

The Alameda County Social Inclusion Campaign's goal is to create welcoming communities by promoting inclusion and eliminating mental health stigma and discrimination. The campaign is run by the consumer led organization Peers Envisioning and Engaging in Recovery Services (PEERS).

For previous FY 14-15	For upcoming FY 15-16, FY16-17
Outcome Statements: • Reduce stigma and discrimination through the direct contact method. **Community Impact:** Research suggests that having contact with people who openly talk about their mental health condition and recovery is the best way to end stigma. To help empower more consumers of mental health to talk about their experiences and provide this contact, PEERS trained a member speaker's bureau, which provided trainings and speeches to the general public of Alameda County. In addition to the general public special efforts were made to reach members of targeted groups. Unique messages and speakers were utilized to help reduce stigma in these targeted groups. PEERS also produced and aired Mental Health Matters educational videos for the goal of reducing stigma and increasing awareness of mental health issues.	No Planned Changes Projected people served: **FY 15/16:** 15,250 people countywide through various efforts **FY 16/17:** 15,350 people countywide through various efforts

B. PREVENTION & EARLY INVERVENTION PROGRAM SUMMARIES

UNDERSERVED ETHNIC LANGUAGE POPULATION (UELP) PROGRAMS

The UELP programs were designed to provide services to historically underserved populations, which the State defined as: Afghan/South Asian, Asian/Pacific Islander (API), Native American, and Latino. Each UELP program is built on a foundation of three core strategies: 1) Education and Outreach, 2) Mental Health Consultation and 3) Early Intervention services. These strategies are implemented through a variety of services such as one-to-one outreach events, psycho-educational workshops/classes, consultation sessions, 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 challenge or mental illness.

In FY 14/15 the data show that these UELP providers in total produced:

- 5,616 prevention events, which is a 14% increase over last year;
- 35,162 people were served at these prevention events; (duplicated count) and
- 539 unique clients were served through early intervention services, which is a decrease from the previous year, but similar to FY 12/13.

Alameda County Behavioral Health Care Services developed and implemented an outcome-based survey in the fall of 2014. The survey was disseminated to the UELP community in 11 different languages: English, Spanish, Vietnamese, Chinese, Dari, Hindi, Khmer, Nepali, Korean, Thai, and Burmese and covered the following domains:

- Connecting individuals and families with their culture;
- Forming and strengthening identity;
- Changing knowledge and perception of mental health;
- Building community and wellness, and
- Improving access to services and resources.

A summary of key findings from the survey (of 213 participants) shows that *in connection with receiving UELP services*:

- 85% of clients reported feeling connected to their culture and community (connection)
- 87% of clients reported feeling confident and good about themselves (identity)
- 75% of clients believe that stress worries and happiness can impact mental and emotional health (knowledge/perception of MH)
- 84% of clients reported knowing people who will listen and support them (community)
- 86% of clients reported knowing where to get help in a crisis (access)
- 72% of clients reported knowing how to get services or resources (access)

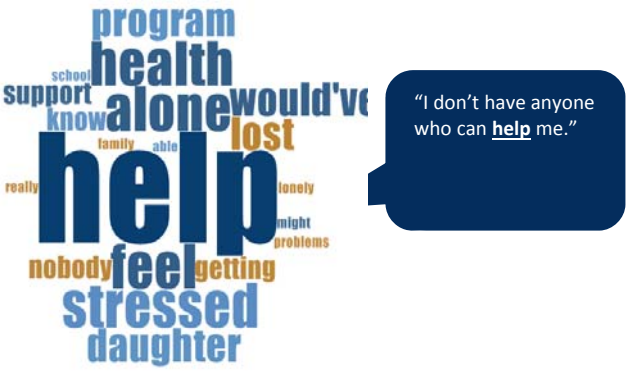
In addition to the above domains, four open-ended questions were also asked in order to better understand: 1) if and how respondents felt services were beneficial to them; 2) what kind of needs they might still have; 3) if and how their lives would be different if they were *not* receiving prevention or early intervention services; and 4) anything else they thought would be helpful for service providers to know.

B. PREVENTION & EARLY INVERVENTION PROGRAM SUMMARIES

Below are the results from open ended question #3:

WHAT WOULD HAVE BEEN DIFFERENT IF YOU HADN'T FOUND THIS PROGRAM OR THESE SERVICES?

Table 3. Different Experiences Without Receiving Services	# of Respondents Reporting That Difference
More Problems/Worse Off/Doing Bad	14
Wouldn't Have Help and Support	14
Alone/Less Social	13
Stressed/Worried	10
Lonely/Depressed	7
Yes, Somewhat Bad	7
Nothing or NA	6
I Don't Know	5
Other Answers	5
Uniformed about services, programs and resources	5



More problems/Worse off/Doing bad was a theme that described how problematic and worse off respondents lives would be if they were not currently receiving services. *"I can't think of life without this program's support."*

Wouldn't Have Help and Support was the other theme that produced the highest number of responses. Respondents repeatedly stated that without these programs and services there would be no one to help them. *"We could not receive the support we needed."*

Yes, Somewhat Bad refers to how respondents' lives would be different if they were not receiving services. Their situations would not be as dire or burdensome as referenced in the themes listed above in Table 3.

In addition to identifying progress and success through the above survey domains the county has also started to analyze early intervention data to determine if access has increased for these historically underserved populations. Three years of data analysis does seem to indicate that access to mental health services has increased. BHCS looked at "access" in two ways: 1) Of the people receiving early intervention services, what percent had received services in our system within the past three years and 2) Of the people receiving early intervention services what percent went on to need mental health treatment services.

For our first question BHCS took a cohort of 352 early intervention clients from FY 14/15 and looked back three years to see if this cohort had ever been served in our system before. The data found that only 17% of these 352 clients had ever been seen before in our system. Reasons for not accessing services will be investigated this year through a number of focus groups; however the data does show an increase in access for a significant number of clients in this cohort.
For the second question BHCS took a cohort of 870 early intervention clients from FY 13/14 and looked forward to see what percent went on to need mental health treatment services. The data found that 15% of the 870 clients went on to receive mental health treatment services (mainly outpatient services) in FY 14/15. This data indicates that the majority of early intervention clients who

are experiencing early signs and symptoms of a mental health challenge or mental illness are being able to receive the appropriate level of care from a cultural lens that they are familiar with; and that for those needing a higher level of care they're being referred for this care. More information will be shared on this indicator of access as data is available and analyzed.

PEI 5. Outreach, Education and Consultation for the Latino Communities
PEI 16. Latino staffing to ACCESS

The UELP program that serves the Latino community is led by the agency la Clinica de La Raza and is called "Cultura y Bienestar" (CyB). It's designed to serve Latinos throughout Alameda County by providing services through a four agency collaborative with each agency leveraging its knowledge and trust in their region to provide services to Latinos in their region of Alameda County. La Clínica de La Raza serves the northern region, La Familia Counseling Service serves the central region, Tiburcio Vasquez Health Center serves the southern county region and East Bay Youth and Family Initiatives serves the east county region. More information on this program can be found at http://culturaybienestar.com

Improve availability of ACCESS and brief treatment clinic/field based services by increasing bicultural staff in one Latino crisis clinic. Includes assessment, brief treatment and referral services.

For previous FY 14-15	For current FY 15-16	For upcoming FY16-17
Total Prevention Contacts: FY 14/15: 17,808 (170% increase over 13/14) 6,950 children and TAY 10,858 adults & older adults **Total Prevention Events:** 2,247 (88% increase over 13/14) **Early Intervention (EI) Clients:248** There has also been a dramatic increase in requests for Cultura y Bienestar Prevention and early intervention services by schools that have provided warm hand-offs to the MH Health Educators and MH Specialists. Cultura y Bienestar receives 5-10 requests/month to facilitate Therapeutic Drumming with the	Mental health education by health educators, trained "Promotores" and MH specialists who are bilingual and bicultural have been successful in reaching community members who are un-served and bridging traditional barriers such as stigma and negative perceptions about mental health issues. Community education continues to help reduce stigma by interchanging the terminology of mental health with emotional well-being, allowing for a more receptive message to be communicated. The emphasis is on promoting a state of well-being, recognizing disequilibrium, and providing tools and resources	No planned changes except an increase in the number of Traditional Healing Community Events, based on the high demand from the community. In particular there will be 10 in the North Region and 6-8 in each of the Central, South and East Regions of Alameda County in FY 15-16. Projected people served: **FY 15/16: 2,275** 1,489 children and TAY 786 adults & older adults **FY 16/17: 2,300** 1495 children & TAY 805 adults & older adults

majority of requests originating from schools. Four Cultura y Bienestar staff have been certified to teach MH First Aid, 6 “Promotores” (Health Promoters) have attended the training and Cultura y Bienestar has trained 68 Spanish speaking community members in MH First Aid (Spanish). This program has also seen a lot of success this year in their outreach and engagement of older adults including workshops and support groups at Senior Centers, Senior Housing facilities, grandparent /grandchild traditional healing events and an ongoing support group for seniors in South county. **Challenges:** Community requests for services are beyond the resources that are available through Cultura y Bienestar so not all requests for services can be fulfilled. Additionally linking community members who need treatment services can be challenging as most services have waiting lists for Spanish services due to workforce challenges recruiting fully bilingual staff. Maintaining staff who are in part time positions is an ongoing challenge for which Cultura y Bienestar is hoping to mitigate through combining several positions to be able to retain our MH Specialists in this project for longer periods of time.	for establishing emotional well-being, physical health, and supportive, healthy relationships in one’s life. CyB has submitted a request for Cultura y Bienestar to be selected as a program for evaluation by UC Berkeley’s MSW program and they’re awaiting news to see if the program was selected to work with the students to design and implement a program evaluation for FY 15-16 and going forward. Cultura y Bienestar is a strong program that has become known, trusted, and respected with services sought after in the community. They hope to continue to build their relationships with the community and evolve services based on feedback that is received from community and participant surveys, and feedback/advice from the Traditional Healers who volunteer on Cultura y Bienestar’s Traditional Healing Advisory Board.	

PEI 6. Outreach, Education and Consultation for the Asian/Pacific Islander (API) Communities

The UELP program that serves the Asian/Pacific Islander (API) Communities is led by two agencies, Asian Community Mental Health (ACMHS) and Community Health for Asian Americans (CHAA) and is called "API Connections". It's designed to serve a diverse range of unserved and underserved API communities through the provision of culturally responsive mental health promotion/prevention and early intervention services. More information on API Connections can be found at http://www.chaaweb.org/programs/apiconnections and http://acmhs.org

For previous FY 14-15	For current FY 15-16	For FY16-17
Total Prevention Contacts: FY 14/15: 8,130 2,818 children and TAY 5,312 adults & older adults **Total Prevention Events:** 1,500 **Early Intervention Clients:164** Within the many API communities there's a high degree of stigma regarding mental health. These numbers above and the impact narratives below are indicative of services that are targeted and culturally responsive and as such people have been interested and open to attending events and utilizing these PEI services; which has helped to *increase access* to PEI services as well as treatment services if necessary. **ACMHS:** Two evidence-based models were made available to API communities: Mental Health First Aid Training in English offered three times and a Cantonese language and a Vietnamese	Currently API Connections is engaged in multiple activities, some of which are highlighted below. ACMHS plans to add "Burmese" language to their Asian language list in their County UELP contract in response to needs in this unserved community. ACMHS continues to collaborate with PEERS' Chinese stigma reduction/social inclusion campaign by hosting a Cantonese support group for Chinese American consumers. There is continued support and collaboration between ACMHS and the county's 10X10 Wellness Campaign and Pool of Consumer Champions (POCC)-Asian American Committee. ACMHS translated POCC and Asian Committee's brochures into Chinese and Korean to improve access for these underserved communities. In addition to ACMHS' bilingual outreach brochures in Chinese, Khmer, Korean and Vietnamese, they have also	No planned changes Projected people served: **FY 15/16: 2,275** 1,489 children and TAY 786 adults & older adults **FY 16/17: 2,300** 1,495 children & TAY 805 adults & older adults

language WRAP group were offered for 10 weeks each. Media outreach was conducted in Cantonese radio and Korean TV and API newspapers of the Bay Area for psychoeducation. New adult support groups were started in native languages for Mien, Korean and Burmese communities, as well as art/wellness groups for Chinese and Korean seniors. This is in addition to ongoing Vietnamese adult and Cantonese parents and Khmer children/youth wellness groups. Has assisted State Mental Health Services Oversight and Accountability Commission to host two API focus groups to pilot their consumer/family member questionnaires to increase API voice/input. **CHAA:** Creation of a Talanoa Circle (open dialogue) to address community issues in the Tongan community. Conversations include domestic violence, traditional gender roles, and how to better support one's family. A monthly support group has continued with Bhutanese women to discuss trauma, family and community violence, and finding hope. A Monthly Thai culture-based Ethic Class for children has started to help them understand their culture and background. This class helps	assisted in the dissemination of "Know the Signs" statewide suicide prevention brochures in Chinese, Khmer, Korean, Vietnamese, Lao and Tagalog. As part of API Connections CHAA supports mental health and wellness in three priority areas: mind/body healing, social and cultural integration, and fair and equitable work. These areas are critical for the well-being of refugees and newcomers (a segment of the API community that CHAA is charged with serving). Their culturally sensitive approaches include: workshops in native language, using sites that are familiar and accessible to the communities, addressing topics that are core to the newcomer experience, and integrating cultural experiences and practices from one's home country into current practices here in the U.S. CHAA has offered a 5 week yoga wellness class for Mongolian mothers to help reduce stress as newcomers and parents. CHAA offers weekly mother's parenting support class with Tibetan women that included wellness and self-care practices such as dancing, laughing therapy, chanting, and discussing important parenting issues.	

to support intergenerational dialogue and reduce conflict within the family. **Challenges:** The PEI demands from the API communities well-exceeded the contracted amount for this program. API consists of 27% of Alameda County's total population and consists of over 40 distinct language and cultural groups. During FY14-15, ACMHS was over-capacity for Early Intervention, serving 125 active clients when they're contracted to serve 60. In addition to high needs, the new moderate-severe criteria for specialty mental health treatment programs funded by Medi-Cal and the waiting list or lack of language capacity for behavioral services in FQHCs or HMOs for the mild to moderate has contributed to this increase in demands for UELP Early Intervention service. A major challenge to conducting ongoing community work is *helping people understand the importance of mental health wellness and prevention.* Communities are focused on obtaining a stable job and housing. Wellness and prevention are secondary needs. CHAA is addressing this challenge by integrating access to concrete resources while also offering PEI services. They also try to capitalize on local issues that are important to the		

community and create dialogue spaces that integrate mental health topics within these issues. An external issue for both of the providers for this program, as well as many others, face is staffing capacity. For FY 14/15, only one of CHAA's staff was full-time. The remaining paraprofessional staff were at 50% or less. This is extremely challenging given the high need of these unserved and underserved communities and limited resources and language support in other systems. As a result, staff often feel overburdened in their community work and have less time to complete paperwork in a timely manner. CHAA is working on this challenge by finding other funding streams to increase FTE as well as helping staff set more realistic priorities for their work.		

B. PREVENTION & EARLY INVERVENTION PROGRAM SUMMARIES

PEI 7. Outreach, Education and Consultation for the South Asian/Afghan Communities

The UELP programs that serve the South Asian and Afghan Communities are run by two prominent community-based agencies, the Portia Bell Hume Center and the Afghan Coalition. Both of these agencies work collaboratively in providing services to these underserved populations. Examples of their activities include (but are not limited to): home visits, gender specific support groups, psycho-educational workshops and presentations, mental health consultations, healing practices that address issues of trauma, low-intensity early intervention visits and other cultural celebrations. More information on this program can be found at http://www.humecenter.org and http://www.afghancoalition.org

For previous FY 14-15	For current FY 15-16	For upcoming FY16-17
Total Prevention Contacts: **FY 14/15: 6,590** 1,061 children and TAY 5,206 adults & older adults **Total Prevention Events:** 1,194 (32% increase over 13/14) **Early Intervention (EI) Clients:80** **Hume Center:** A high level of satisfaction was reported by participants that received EI services. Most participants reported positive changes in their symptoms and interpersonal relationships and felt better connected to their support systems. Here are two quotes from participants: “This (consultation) is the best thing that has happened to me”, “I have felt connected to a person who understood me and my cultural dilemmas for the first time and was not just someone in a white coat”. There have also been a higher number of self-referrals particularly from males. This reflects a changing trend as the services are becoming more well-known and accepted by the community. A townhall panel discussion was organized and coordinated with the other social service agencies, e.g. law enforcement, restorative justice department,	The community mental health specialists continue to outreach and engage the various South Asian communities in order to reduce stigma and discrimination, increase access to mental health services and provide consultation and engagement. The Hume Center continues to provide training to volunteers from High Schools in Fremont to do outreach to the community. Student volunteers table at Health Fairs and address other student bodies to spread awareness about mental health and reduce stigma. They have also expanded services through St. Bede’s school in Hayward. They provided consultation services with the principal and collaborated with staff and parents to support the participants .High levels of satisfaction were reported by the principal and students. In FY 14-15 the Afghan Mental Health Project launched it	No planned changes Projected people served: **FY 15/16: 875** 455 children and TAY 420 adults & older adults **FY 16/17: 900** 468 children & TAY 432 adults & older adults

psychologists, parents, school, My Sahana and the Sikh Coalition.

Afghan Coalition: In the past one of the biggest challenges for this program was in getting participants to even begin the conversation on mental health. This year the program had 445 one-to-one prevention interactions with clients in the office. The staff used every one of those occasions to help bring awareness to the topic of mental health issues. The one-on-one approach helped the clients become comfortable with the topic and made them much more open to ask questions. This approach made clients feel they could discuss their issues and concerns without fearing what others around them might think.

This program increased its presence at local Afghan community events and strengthened its relationship with community leaders. The program was part of 49 Afghan community events this year. Such a presence allowed the project to reach out and touch on mental health topics from a culturally sensitive perspective. Having community leaders at these events introduce the Afghan Mental Health program enabled the public to see the topic of mental health being addressed by their own leaders, helping reduce the stigma attached to it.

Challenges: As with many of the UELP programs the challenge of overcoming mental health stigma and engaging communities is always present. These programs have been able to mitigate this challenge through not using labels or mental health jargon and utilizing community leaders to introduce and speak about various mental health topics.

There has also been a challenge around the commitment to long term support groups due to the stigma for mental health that is prevalent in the South Asian community. Interest in “groups” is typically expressed at community outreach events

Facebook page, which now in FY 15/16 has received over 2,000 likes.

Additionally, in FY 15/16 due to growth in the number of clients, the Afghan Mental Health Project will be moving to a larger location in Fremont. This will allow for confidential EI services as well as drop-in information and referral services.

There are also additional goals for the Afghan Mental Health Project to partner with a variety of Fremont schools to continue to develop relationships and leverage resources for the youth and families in these communities.

but few people tend to actually participate. Instead the Hume Center has provided support through workshops which do not require participants to identify themselves as going through a challenge and yet benefit from information and support around it. However there is still a need for more support groups particularly for seniors and parents. So this program will continue to look for innovative engagement strategies. For the Afghan Coalition staff turnover in the youth outreach position has caused lack of consistency for youth activities. A new staff has been hired to help facilitate activities, so this should not be an issue in FY 15/16. The program is also working diligently to set up a process that would allow work to flow easily between various outreach workers should the need arise.		

B. PREVENTION & EARLY INVERVENTION PROGRAM SUMMARIES

PEI 8. Outreach, Education and Consultation for the Native American Communities

The UELP program that serves the Native American Communities is led by the community organization the Native American Health Center (NAHC). This PEI program run by the NAHC is called the "Native American Prevention Center." A majority of the program activities take place on site at the S.A.G.E (Spirit, Art & Culture, Guidance and Encouragement) Center. To date this program, has been very successful in providing culturally appropriate mental health promotion/prevention and early intervention services to the Native American community.

For previous FY 14-15	For current FY 15-16	For FY16-17 (July 1, 2016-June 30, 2017)
Total Prevention Contacts: **FY 14/15:** **2,131** **970** children and TAY **1,161** adults & older adults **Total Prevention Events:** **461** **Early Intervention (EI) Clients:44** The S.A.G.E. Center has had a number of impactful projects during this time period including: 1) The introduction of the Resource Circle, a series of drop-in groups aimed at building our communities ability to navigate Alameda County's mental health and human services systems. 2) In May 2015 the S.A.G.E. Center held their annual Sage Gathering and Wrapping for their community. This provides access for the Native community to touch, wrap and handle the medicine in its natural form. They prepare this medicine for ceremonial use in their community for the entire of year. It provides the Native community with a way to heal by providing a connection to a traditional and sacred medicine. Once again, this year over 1,000 sage bundles were created at this event.	The PEI Natural Helpers continue to help reduce stigma by interchanging the terminology of mental health with the idea of "being out of balance". This culturally relevant/responsive interpretation of the concept of mental health/illness allows for a more receptive message to be communicated. **Early Successes:** The Annual Youth GONA (Gathering of Native Americans) took place in August 2015, and was a great success. Each year, 40-50 inner-city youth from Oakland, San Francisco, Richmond, and San Jose register to take part in this cultural event. The youth are transported to the scenic Marin Headlands for 4 days of cultural activities that are centered on building resiliency, generosity, community, and re-connecting with spirituality. NAHC is working with other agencies to measure the effectiveness of this intervention over time. August 1st, 2015 marked the 14th Annual Gathering of the	No planned changes **FY 15/16: 875** 455 children and TAY 420 adults & older adults **FY 16/17: 900** 468 children & TAY 432 adults & older adults

3) Throughout the past year, the Native American Health Center was able to begin to increase the number of Native American traditional healers hosted by the agency. The Native American Traditional Healers are brought on to perform ceremonies and provide counseling and traditional healing practices to the members of the urban Indian community. These ceremonies are typically only conducted on reservations or other rural settings, so having the ability to bring the healers onsite is an extremely valuable asset. **Challenges:** As with many of the UELP programs the challenge of overcoming mental health stigma and engaging communities is always present. This program has been able to mitigate this challenge through using the term historical trauma (HT, which both empowers the community and reduces stigma as it's a term that takes into consideration the context of Native experiences in response to federal policies. Historical trauma responses (HTR) is a constellation of features including substance abuse, suicidal thoughts, low self- esteem, bursts of anger, difficulty with relationships, unresolved grief, mood regulation. All new hires to the Native American Health Center learn about HT and HTR as part of their new employee orientation. The S.A.G.E. Center conducts on average 2-3 of these trainings a month for staff and the community.	Lodges event. This event emphasizes Substance Abuse prevention and recovery, and does so in a culturally relevant manner. The full day event involves Native American traditional healers, Native American dancing, several guest speakers, and attendees from various Native American focused substance abuse treatment facilities throughout Northern California. Approximately 400 members registered to attend this event.	

B. PREVENTION & EARLY INVERVENTION PROGRAM SUMMARIES

PEI 9. Mental Health - Primary Care Integration

Build behavioral health capacity in primary care clinics with Federally Qualified Health Centers (FQHC) delivering primary care in the County. The project uses the AIMS model, provides training to FQHCs and incentives to encourage those clinics to develop behavioral health positions.
FY 14/15 Outcomes, Impact & Challenges: Despite Behavioral Health staffing changes at all of the FQHCs during FY 14/15, BHCS has been able to increase the level of participation by all of the Community Health Centers in the Integrated Behavioral Health Program (IBHC). The BHCS staff working on the integration projects with the Community Clinics is not only attending the monthly Alameda Health Consortiums' Behavioral Health Clinicians meeting and trainings, but also taking an active role in the discussions. This new level of collaboration between the Safety Net health care providers and behavioral health staff has benefited not only Alameda County residents but also all the staff of each community health center.
FY 14/15 Progress Report: Eight of the nine Alameda Health Consortium's Community Health Centers actively participated in the Integrated Behavioral Health Program that focused on the recruitment and retention of licensed Behavioral Health Clinicians and participation in the monitoring of the Pay for Performance measures of patient treatment progress. The eight Consortium Health Centers that completed their BHCS Integration contracts, and are working with staff to identify new performance measures that will improve patient behavioral health treatment outcomes and strengthen their ability to serve Alameda County residents with behavioral health concerns.
FY 15/16 Plans: BHCS implemented the county-operated Psychiatric Consultation Service in 8 of the nine Alameda County Community Health Centers. All of the Community Health Centers have expressed that this new service has been of tremendous value to their primary care and licensed behavioral health providers in their treatment of clients with behavioral health concerns as well as improved their ability to prescribe psychotropic medications. BHCS is currently meeting with the Alameda Health Consortium Leadership to discuss renewal of this valuable service as well identify ways new ways to work as a team in the primary care clinic setting that will improve quality of care and patient services. BHCS is also meeting with the Alameda County, Department of Public Health, Office of AIDS, to plan for providing two HIV/AIDS Health Centers access to the Department's Psychiatric Consultation Services.

PEI 12. Trauma Informed Care/Suicide Prevention

Crisis Support Services of Alameda County (CSS) is a nonprofit, volunteer-based crisis intervention and suicide prevention agency. They provide a variety of mental health services to a wide range of persons in varying degrees of crisis. Services include crisis hotline, school-based suicide prevention training, community gate keeper trainings and consultation, Mental Health First Aid, teen text line, trauma informed care trainings, grief counseling for all ages and crisis event counseling. *Their primary mission is to assist people in emotional distress, to offer supportive counseling to those in crisis and to prevent suicide.*

CSS is leading the way for suicide prevention centers across the nation in providing sensitive and timely services to people impacted by traumatic stress. Trauma-Informed Care (TIC) is a person-centered response that focuses on improving functioning over curing mental illness, i.e. "fixing"

something “broken”. CSS utilizes a wide range of TIC components and responses when working with all of their clients, but predominantly with those affected by traumatic loss, particularly suicide and homicide bereavement.

For previous FY 14-15 Also see **ATTACHMENT C** “Crisis Support Services Year End 2014-2015 Reports” for more details.	**For current FY 15-16**	**For upcoming** **FY16-17** **(July 1, 2016-June 30, 2017)**
Impact **Clients Served FY 14/15:** <u>24 hr. Crisis Line</u> responded to 60,734 calls on the 3 Alameda County call lines (24 hour Crisis Line, Al Co. Behavioral Health ACCESS Afterhours Lines, National Suicide Prevention Lifeline.) For the Crisis Line Program alone 185 volunteers and interns contributed over 18,720 hours on the crisis lines this year The <u>Teens for Life (TFL) Youth Suicide Prevention program</u> served 9,188 youth through 306 presentations at 31 schools in 14 out of the 18 Alameda County School Districts. Post TFL training: • 81% strongly agreed or agreed with the statement “*I can recognize if someone close to me is feeling suicidal.”* As compared to only 46% pre training. • *79%* strongly agreed or agreed with the statement “*If I had a friend who was feeling depressed or suicidal, I would be willing to call a crisis line.” As compared to only 61% pre training.*	In FY 15/16 all of the suicide prevention programs and trauma informed care strategies are going strong. For youth, there appears to be strong connection between the TFL suicide prevention trainings and increased knowledge about the text line resource. This is evidenced through youth mentioning the TFL presentations when using the text line. Additionally, Alameda County BHCS has asked CSS to create a 4-hour “floor training” on trauma-informed care principles for county staff and its community partners. The goal of this training is to encourage providers to become a trauma informed organization with the hope that clients who receive care do not experience re-traumatization as they receive service. See the comments below from several of the programs to better understand the impact these programs are having: **Comment from a Crisis Line Caller:** I would just like to say, when someone listens to me, they are not judging me. It is	• No planned changes Projected people served: • **FY 15/16: 13,800** 12,850 children and TAY 950 adults & older adults • **FY 16/17: 13,900** 12,900 children & TAY 1,000 adults & older adults

The Youth Crisis Text Line conducted 833 crisis texting sessions in FY 14/15, which is a 64% increase from FY 13/14 of 509.

The group and individual counseling program served a total of 478 clients (224 youth, 172 older adults, and 82 grief counseling clients) for a total of 5419 sessions -all through the lens of being trauma informed and for many individuals addressing the traumatic issue within the counseling sessions.

Community Education & Consultation Trainings served 1,016 adults through 26 trainings.

Post training 89% strongly agreed or agreed with this statement *"I feel confident in my ability to ask directly about suicide."* As compared to only 31% pre training

Challenges:

Access to teachers and parents in school systems are still a challenge. This has been mitigated somewhat through continued collaboration with the PEI funded school district mental health liaisons, but remains an ongoing challenge to be addressed each school year.

very useful to me and I get so sad, it's not good to be judged when you are sad. I'm just trying to get through a difficult time and this has been very helpful.

Student Comment from the Teens for Life Youth Suicide Prevention Program: *"I used to think that learning about suicide wouldn't be very helpful, that common sense would kick in. I now know that isn't the case and I feel prepared to help anyone who may feel depressed or suicidal".* 14 year-old

Based on the data from the crisis text line these are the areas where youth are struggling the most:

Loneliness/isolation
Anxiety/stress
Depression
Non-suicidal self-injury

CSS has also developed a number of new collaborations in FY 14/15 including a partnership with the Oakland Police Department (OPD), Ohlone College, and la Clinica de la Raza where a youth intern program has been established.

CSS also partnered on developing 2 new evidenced-based suicide prevention practices to help LGBT Older Adults and Law Enforcement.

PEI 13. Wellness, Recovery and Resiliency Initiative

The Wellness, Recovery and Resiliency Initiative's (WRRI) aim is to support "systems transformation" by helping behavioral health programs integrate wellness practices into culture and operations. The WRRI is staffed by people trained in organizational development and meeting facilitation, who also had "lived experience" with the public mental health system as clients and family members. The WRRI offers workshops and technical assistance in the form of recovery education workshops, action planning workshops; recovery event planning; meeting facilitation training and leadership training for boards of directors and management teams. These workshops, ongoing classes and events were designed to help clients build wellness-oriented experience, knowledge, skills and practice. The WRRI continues to implement quality improvement activities and lead initiatives including ongoing best practices, promoting consumer and family involvement and peer support. The WRRI also supports consumer and family stipends, training and conference costs.

FY 14/15 Outcomes, Impact & Challenges

- **Reach Out** provides services to mental health clients within locked facilities and licensed board and care providers. The role is to eliminate isolation, facilitate the process of consumers planning for the transition of discharge and addition community supports, and some housing advocacy through peer support
- **Berkeley Drop In Center** provides vital services for mental health clients who are also experiencing chronic homelessness and AOD issues. The center offers ongoing housing services, payee representation for consumers, daily food, peer support groups, and other referral services
- **MHSA Leadership Development** provides conference coordination and ongoing community education for POCC members within Alameda County in partnership with ACBHCS Consumer Empowerment Department
- **Reaching Across** provides community activities for mental health consumers who have experience isolation, peer counseling and advocacy. The center also offers physical wellness tools, music and art therapy.
- **Bestow!** provides an 8-week training program and a 6-month paid internship for consumers with a desire to work within the mental health system as Peer Specialist. BestNOW also facilitates a variety of employment readiness workshops and Medical documentation trainings.
- **Tenant Support Program** provides direct housing supports such as move in costs, housing applications, housing advocacy and education, wellness groups and peer support for mental health consumers

B. PREVENTION & EARLY INVERVENTION PROGRAM SUMMARIES

FY 15/16 Progress Report

Reach Out serves Adults and some older adults

- Increase operating costs have decreased the number of active volunteers we can fund, decrease of supplies and transportation
- **Projected 16-17**:
    - Increased program and operating expenses
    - Decreased of site visits and volunteers

Berkeley Drop In Center serves adults, adults with children, some older adults and some

- Increased operating cost (Rent, Supplies, and Utilities).
- **Projected 16-17:**
    - Increased operating cost (Rent, Supplies, and Utilities).
    - Potential loss of funding from the City of Berkeley ($85k)
    - Reduction in housing and AOD services

Reaching Across serves adults and older adults.

- Increased operating cost (Rent and Utilities).
- Projected 16-17
    - Increased operating cost (Rent and Utilities
    - No projected shift in services

BestNOW! serves adults and older adults.

- New LOCATION – 8105 Edgewater Drive Suite 100 (South Wing)
- **Projected 16 -17**
    - No Projected shifts in services

Tenant Support Program serves adults, adults with children and older adults.

- Increased operating cost (Rent and Utilities)
- The program will provide WRAP groups on site for housing participants
- **Projected 16 – 17 –**
    - Increased operating cost (Rent and Utilities)
    - No Projected shifts in services

B. PREVENTION & EARLY INVERVENTION PROGRAM SUMMARIES

PEI 15. Asian Pacific Islander staffing to ACCESS

Improve availability of ACCESS information and referral; and brief treatment services by increasing bicultural staff in one Asian Pacific Islander crisis clinic. Services include phone referrals, assessment, outreach and brief crisis stabilization treatment.

FY 14/15 Outcomes, Barriers and Challenges:

- Provided phone and walk in screening, referral services to 1137 unduplicated individuals. Over 825 were mental health-related enquiries, referrals or screenings.
- Intake/referral/screening services were provided in English (33%); Cantonese (25%); Vietnamese (11%); Mandarin (8.5%) and other languages such as Khmer, Korean, Tagalog, Burmese, Karen and Mien.
- Provided short term crisis stabilization treatment services to 147 clients. 14% of clients treated were over 65 years old, as compared to 11% of FY13/14.
- Conducted and/or participated in 14 outreach events, reaching over 900 community members. Through psychoeducation materials, workshops, mental health presentation, WRAP group and wellness events, we raise community members' awareness of mental health issues, stress management and availability of treatment resources. Communities reached include Chinese and Vietnamese speaking community, school age parents, college students, older adults, LGBT community and caregivers group.
- Notable community impacts were made on
  A. increasing peer workforce development and peer-led group
    - Two Vietnamese and one Cantonese speaking peers got certified as WRAP group facilitator;
    - One Korean speaking peer graduated from BEST NOW peer counselor training program;
    - First ever peer-facilitated 10-session Chinese and Vietnamese WRAP group were conducted, reaching a total of 19 individuals.

  B. streamlining mental health referral process with primary care providers, incorporating the moderate-severe algorithm of specialty mental health services eligibility criteria.

  C. increasing mental health screening and treatment capacity for emerging Burmese and Karen speaking communities. Served 16 this year.

- Barriers:
    - inadequate bilingual API behavioral health providers
    - lack of culturally responsive community wellness/safety net programs for individuals who do not or no longer meet specialty mental health services criteria

FY 15-16 Plans:

- Continue to provide screening, info and referral services to API communities. Goal is to reach 1150 unduplicated individuals.
- Provide short term crisis stabilization treatment services to 150 clients.

- Conduct WRAP groups in at least two Alameda County threshold languages. WRAP group will be offered to community members who, during intake, do not meet moderate-severe specialty mental health services criteria but need the wellness-focused connection to sustain stability and community placement.

FY 15/16, 16/17 Plans:

- Perform screening, assessment and referrals for Spanish speaking Latinos 5 half days per week. Launch clinic wide open access assessment model supported through the use of collaborative documentation. Offer clients either scheduled appointment and walk-in assessments to allow for greater access to services for FY 15-16. Study client selection and relationship to "no show" rates. Conduct focus group with clients to get feedback about their experience with collaborative documentation to plan for future years.
- Provide brief treatment/crisis stabilization services to 150 clients.
- Perform 350 Assessments to provide level of care determination • Providing 4 Spanish groups per week including WRAP, Peer Activity, Depression and Trauma facilitated weekly by Peer staff or Peer & Clinical staff together for outreach/engagement and symptom monitoring.
- Continue to implement and assess effectiveness of text messaging support for participants in Spanish depression group.

PEI 18. Behavioral Health Medical Home

Provide BHCS consumers with serious mental illness timely access to primary health care services in Alameda County Adult Mental Health Community Support Centers (CSC).

FY 14/15 Outcomes, Impact & Challenges: During FY2014/2015, Alameda County completed its fourth and final year as a Substance Abuse Mental Health Services Administration (SAMHSA), Primary Behavioral Health Care Integration (PBHCI) grantee. At the end of the grant, BHCS had two operational Promoting Access To Health (PATH) primary care clinics providing health services to BHCS SMI consumers in Oakland and Fremont, California. In addition to primary care services, both service sites were able to offer program participants health and wellness education classes and activities. At the end of the fourth year, both sites had a participant retention rate over 80%. The health and wellness education classes and activities included nutritional cooking, lunch and learn information presentation discussion groups, walking groups, stress reduction, and implementation of the "Community Connections" program. At the end of FY 14/15 over 60% of the enrolled PATH Project clients had participated in at least one health and wellness class or activity.

The PATH Project also continued working on new ways to improve the sustainability of the primary care services and health and wellness activities. The most successful effort has been to establish a new collaborative partnership with another BHCS provider. In March, 2015, the PATH Project at Oakland Community Support Center started accepting clients from the Telecare's CHANGES Program which serves consumers with mental health and substance use disorders. Today CHANGES is sending over 26 of their clients over to the Oakland PATH Clinic for primary care services from LifeLong Medical Group staff. This has proven to be a very successful Financial model that BHCS will be able to use to help cover the costs of primary care services as well as build new collaborative relationships.

B. PREVENTION & EARLY INVERVENTION PROGRAM SUMMARIES

In June, 2015, the Oakland CSC started a new four year contract services with the University of California, Berkeley, School of Psychology to provide sleep improvement services for up to 120 Oakland CSC participants. The funding for this new service at the Oakland PATH is from a four year grant UC Berkeley received from the National Institute of Mental Health in November, 2014. The contract with BHCS is for $169,000.

FY 15/16 Program Plans: The implementation of the two new PATH Project Clinics at Eden Adult Community Support Center and the Gail Steele Wellness and Recovery Center have both faced delays. The Eden Adult Community Support Center delays have been due to identifying adequate space for the primary care services as well as getting cost estimates for the renovation of two offices into examination rooms without having to make major changes in the building's fixtures. BHCS is working closely with Alameda County's General Services Administration to make sure the right space is selected.

Tiburcio Vasquez Health Center has had to delay the start of the PATH Project's primary care services at the BHCS Gail Steel Wellness and Recovery
Center located in Hayward. The reasons given to BHCS for the delay is due to them having recently opened a new 20,000 square foot primary care clinic in Union City and a new school based health center located at Hayward High School in Hayward. They hope to be ready to move forward with the Gail Steele Project by October, 2015.

To show continued support for the integration services, on July 13, 2015, BHCS Executive Leadership approved the rollover of the 2014/15 MHSA Medical Home funding to start the two new PATH Project Clinics at Eden and Gail Steele. Once the final space for the primary care clinic is identified at Eden, the contract negotiation with LifeLong Medical Care for the provision of primary care services at the site will begin.

C. INNOVATIVE PROGRAMS SUMMARIES

Program Description: Innovative Programs

FY 15/16 Plan Update:

Round Three Innovative Grant Cycle

Implementation of INN 3 grant projects was completed by December 2015.

The Round Three Innovative (INN3) Grants Learning Conferences will highlight grant projects and outcomes to the community. Two distinct INN3 Learning Conferences will be conducted, one for Isolated Adults and Older Adults projects (January 22, 2016) and another for LGBTQI2S (March 24, 2016). Evaluation of project outcomes will be conducted in FY 2016.

INN3 grantees (below) developed and submitted final program designs addressing the needs of Isolated Adult and Older Adult Consumers**.**

Project Name	Grantee	Project Outcome
1. City of Fremont Peer Mental Health Coach Program: A Community Mental Health Model	City of Fremont / Human Services Department	Train Peer Mental Health older adults with SMI matched with isolated adults with SMI (age 50+) as MH Coaches.
2. Special Message Project	PEERS	Community Relations Managers and Peer Outreach specialists will be trained to outreach to fifty isolated adult consumers.
3. Reaching In: Reducing Isolation Due to Mental Illness by Partnering With Family Members/Loved Ones	CJM Associates / Center for Family Counseling/ Bay Area Community Services (BACS)	Family Healing: engage the family and isolated consumer through a 12-week workshop series using narrative based story telling and family/cultural genograms, and addressing stress.
4. An SRO Culture of Inclusion to Decrease Isolation Among Residents with Serious Mental Illness	Public Health Institute	Increase engagement with isolated consumers SRO through physical, social, and spiritual activities, including computer-based cognitive training.
5. Project Asian Reach (PAR): Home and Place-based Outreach to Chinese and Korean Isolated Older Adults	Asian Community Mental Health Services	Train culturally appropriate peers and family members paired with bilingual mental health clinicians to launch home-based and place-

		based outreach to reduce isolation of and increase use of mental health services by monolingual Chinese and Korean adults/older adults with SMI.
6. PEP: Peer Elder Program	St. Mary's Center	Elder leaders outreach to isolated older adults with mental illness where they live and develop appropriate assessment and engagement.
7. THRIVE: Teaming Housing Residents with Interest-Based Volunteer Exercises	Berkeley Food and Housing Project	Outreach with a network of non-profit and volunteer placement sites for isolated adults living in Board and Care facility.
8. Asian Elder Wellness Project	Community Health For Asian Americans, with community partners Center for Empowering Refugees and Immigrants (CERI), Filipino Advocates for Justice (FAJ) and Korean Community Center of the East Bay (KCCEB)	Core leadership groups (CLGs) will identify culturally responsive strategies for SMI adult and older adult Cambodian refugees, home care providers from the Filipino community, and Koreans living in housing facilities.
9. Stepping Out and Reaching In (SOAR)	Senior Support Program of the Tri-Valley	Peer mentoring program addressing nutrition, medication management, healthy choices, stress management, and connecting with community.
10. Refugee Well-Being Project	International Rescue Committee	Provides culturally/linguistically appropriate services to isolated refugee adults and older adults including intake and assessment of mental health needs, referral and case management, peer group health education, etc.

C. INNOVATIVE PROGRAMS SUMMARIES

The LGBTQI2S grant projects (below) developed and submitted one project deliverable (program design, welcoming toolkit or a provider training curriculum) to address the needs of LGBTQI2S Clients and Consumers.

Project Name	Grantee	Project Description
1. LGBTQI2S Welcoming Strategies Toolkit for Providers	The Pacific Center for Human Growth	Develop a LGBTQI2S Welcoming Toolkit using site visits, materials review, trainings, and an audit of forms and phone procedures.
2. Rainbow to Wellness	Asian Community Mental Health Services	Develop a Welcoming Toolkit for LGBTQI2S clients/consumers, with special considerations to the Asian and Pacific Islander clients and consumers.
3. Unconditional Pride: A Clinical Framework for Partnering with LGBTQI2S Youth and Allies	Seneca Center	Create two curricula (for Children and TAY) with the expertise of local LGBTQI2S youth and their families and providers, and integrated with Seneca's "Unconditional Care" treatment model.
4. Critical Conversations: Talking About LGBTQI2S Transition Age Youth & Mental Health	Our Space, a program of Bay Area Youth Center	Design a training curriculum that is rooted in the experiences of LGBTQI2S TAY impacted by mental health, via digital storytelling and technology.
5. Community Inclusion Project for Age-Based LGBTQI2S Provider Training Curriculum	The Pacific Center for Human Growth	Develop a LGBTQI2S Provider training curriculum for each age group that will assess the current use of culturally sensitive language and identify cultural competency issues among BHCS providers, and facilitate "learning meetings" in small groups with providers and consumers.

6. Addressing LGBTQI2S Elder Healthcare Disparities: Developing Tools for Online Training	Lavender Seniors, a project of Life Elder Care	Develop an online learning tool to increase provider access to a training to outreach to LGBTQ older adults.
7. Lambda Youth Project - Children	Horizon Services, Inc/ Project Eden	Develop an LGBTQQI2-S Training Curriculum that supports age-based, culturally responsive provider capabilities regarding emotional, developmental, physical, social, and mental health needs and issues for LGBTQQI2-S children.
8. Lambda Youth Project - TAY	Horizon Services, Inc / Project Eden	Develop a LGBTQQ2-S Training Curriculum that supports age-based, culturally responsive provider capabilities regarding emotional, developmental, physical, social, and mental health needs and issues for LGBTQQI2-S TAY.
9. Alameda County Peer Support and Congregations Collaborative – Education and Peer Support Project	California Institute of Mental Health (CiMH)	Develop a best practices program design to work effectively with family members for unserved/underserved, low income, LGBTQI2S African Americans and others of color, their families/allies.
10. Improving LGBTQI2S competency for providers through small group trainings and follow up supports	The Pacific Center for Human Growth	Develop a training template to improve competence in how to reduce barriers for LGBTQI2S people accessing mental health services, based on a small group conversational training model.

	11. Adapting Supports for LGBTQI2S people and their families based on the intersections of age and cultural considerations	The Pacific Center for Human Growth	Utilize collaboration, materials creation, small age-based group field test trainings, and LGBTQI2S community meetings to engage the public in addressing the isolation of LGBTQI2S people of all ages.	
	12. Oyate Tupu'anga Project: Healing Indigenous Two Spirit and Takataapui Communities	Community Health for Asian Americans – with community partners Bay Area American Indian Two Spirits (BAAITS), and Community Health for Asian Americans' Pacific Islander Community Advocacy	Utilize Native American and Pacific Islander traditional cultural practices to bring Native American Two Spirit and Pacific Islander Takataapui people of all ages together to decrease social isolation and to assist with emotional disturbance and serious mental illness.	
	13. Alameda County Peer Support and Congregations Collaborative – Welcome Toolkit Feedback	California Institute for Mental Health	Predominantly African American member churches will develop a Welcome Toolkit for LBTQI2S consumers by conducting focus groups and 1-1 interviews.	

D. WORKFORCE, EDUCATION & TRAINING PROGRAM SUMMARIES

Alameda County Behavioral Health Care Services (BHCS), Workforce Education & Training (WET) uses six strategies to build and expand behavioral health workforce capacity:

1. Workforce Staffing Support
2. Consumer and Family Training, Education and Employment
3. Training and Technical Assistance
4. Internships
5. Educational Pathways
6. Financial Incentives

1. Workforce Staffing Support

Program Description: Provides infrastructure to manage the development, implementation and evaluation of all Workforce Education and Training (WE&T) programs and initiatives. Spearheads partnerships with community-based organizations, peer-run agencies, educational institutions and local, regional and state agencies.

FY 13/14 Outcomes, Impact & Challenges:

- The WET manager and staff attended and actively participated in the Bay Area WET Collaborative meetings; twice monthly WET coordinator conference calls
- WET staff actively participated in the Regional Partnership Workforce Education and Training (WET) Steering Committee meetings
- WET manager provided oversight of the Bay Area Regional Partnership contract, as BHCS serves as the fiscal sponsor and employer for the state funded Regional Partnership Program
- The WET team administered and implemented previously approved WET strategies such as the Graduate Intern Stipend Program and the State Mental Health Loan Assumption Program (MHLAP)
- WET team developed and administered a workforce needs assessment survey which was sent to all BHCS county-operated and county contracted community-based behavioral health organizations to identify current BHCS workforce needs
- Shared executive summary report with the focus group participants, BHCS Director and MHSA stakeholders
- Presented results of the survey to the MHSA stakeholders committee, Training Committee, and Alameda Council of Community Mental Health Agencies

Workforce Staffing Support continued…
FY 14/15 Progress Report:

- WET manager worked with BHCS PEI Coordinator on a proposed training plan submitted by Community Health for Asian Americans (CHAA). WET funded a pilot mental health workforce development model for Alameda County's unserved and underserved new and emerging immigrant and refugee communities

- The WET team collaborated with various primary applicant organizations including BHCS Consumer Empowerment Unit, Berkeley City College (BCC) - Public and Human Services Program, Health Care Services Agency (HCSA), Alameda County Health Pipeline Partnership Program (ACHPP), Mentoring in Medicine and Science (MIMS), and Diversity in Health Training Institute on applying for the following grants as a collaborative partner:

    - OSHPD Peer Employment and Placement

    - OSHPD Peer Personnel Training and Placement RFA – BCC received funding

    - National Diversity Grant – "Health Careers Preparatory Academy"

    - OSHPD Mini Grants – Alameda County Pipeline Partnership Program, Mentoring in Medicine and Science, and Diversity in Health Training Institute– all three partners received funding

- Prepared standard service agreement with BHCS and UCSF, School of Medicine to provide behavioral health education and clinical training to Fellows from UCSF Public Psychiatry Fellowship (PPF) Program. This agreement will provide an opportunity for fellows to consider public mental health as a career choice with an objective of recruiting viable candidates into ACBHCS system of care. ACBHCS Crisis Residential Program (CRP) program will provide PPF fellow(s) beneficial educational opportunity at the CRP outpatient/crisis clinic, at the same time, enable ACBHCS to develop a recruitment pipeline for ACBHCS system of care in need of psychiatrists

- WET staff served on various BHCS advisory committees, such as Consumer and Family Member Employment workgroup, BHCS Training Committee, Merritt/Laney College Disability Student Services Stakeholders Committee, WET Regional Partnership Steering Committee, Pool Of Consumer Champions Employment Taskforce

- WET staff coordinated a four day Interpreters training for BHCS staff with the WET Regional Partnership Program

Workforce Staffing Support continued…

FY 14/15 Progress Report:

- Organized and held an annual WET strategic planning meeting with WET team
- WET Staff has expanded responsibilities for providing administrative functions for Children's System of Care (CSOC), Adult System of Care (ASOC) and Criminal Justice Mental Health Services/Conditional Release Program (CONREP) internships
- Processed funding agreement between BHCS, as the fiscal sponsor, and OSHPD to fund and implement the Bay Area Regional Partnership program for FY 2014 through 2017
- BHCS will continue to serve as the fiscal sponsor for this funding as outlined in the OSHPD Agreement Number 14-5004, which will include passing through the funds to CiMH. WET manager will continue to provide contract oversight

FY 15/16, 16/17 Plans:

- WET team will continue to administer and implement WET strategies
- Prioritize, develop and implement projects based on the workforce needs assessment survey outcomes
- Evaluate WET program impact and needs; based on program outcomes and data, continue to enhance and implement activities to achieve WET goals

2. Consumer & Family 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 13/14 Outcomes, Impact & Challenges:

BHCS has developed and implemented the following activities:

- Estimated 140 consumer and 79 family employees in Alameda County and community based organizations (CBO)
- Provided employment opportunities list serve for consumers and family members
- Convened ongoing Consumer & Family Employment Work Group meetings to learn, discuss and problem solve consumer and family employment content & issues

D. WORKFORCE, EDUCATION & TRAINING PROGRAM SUMMARIES

- Offered Family Leadership and Family Advocate Training Programs through the Family Education Resource Center
- Implemented annual BEST Now! Consumer Employment Training Program with 6 month internships
- Provided Supervisorial Training
- Consumer and Family Employment Liaison provided ongoing participation and support of CiMH Greater Bay Area Workforce Collaborative Steering Committee
- Established partnership with Berkeley City College (BCC) Public and Human Services program to increase access for our consumers and family members entering community college
    - Organized outreach event in collaboration with BCC to 32 consumer participants – 2 participants enrolled
- Initiated development of "learning collaborative" for managers who are working with consumer and family employees to provide technical assistance and support
- Developed and submitted approved Peer Navigator Program pilot plan
- Participated & contributed to WWT's Peer Certification conference
- Provided job readiness events "Dress for Success" Clothing Boutique Exchange - 75 consumer recipients

Consumer & Family Training, Education and Employment continued…
FY 14/15 Progress Report:

- Estimated 142 consumer providers and 86 family employees in Alameda County and community based organizations

- Provided employment opportunities list serve for consumers and family members

- Convened ongoing Consumer & Family Employment Work Group meetings to learn, discuss and problem solve consumer and family employment content & issues

- Continued development of "learning collaborative" for managers who are working with consumer and family employees to provide technical assistance and support
    - Facilitated planning workshop for "learning collaborative"– 17 supervisors attended
    - Facilitated initial meeting – 23 managers attended

- Provided Family Leadership and Family Advocate Training Programs through the Family Education Resource Center

- Implemented annual BEST Now! Consumer Employment Training
- Program with 6 month internships: June 12, 2014; 21 graduates
    - Provided assistance with screening applicants and interviewing
    - Supported BEST Now with marketing for their employment skill-building workshops

- Consumer and Family Employment Liaison provided ongoing participation and support of CiMH Greater Bay Area Workforce Collaborative Steering Committee

    - Assisted with planning for the Human Resources Forum

- Berkeley City College Public and Human Services Programs
    - Organized two outreach meetings with BCC & BEST Now & POCC members

- Researched viability and developed a proposal to establish an Alameda County "Job Board" website

- Partnered with ACBHCS Consumer Empowerment Team & MHASF in their application for Peer Personnel Preparation RFP (put out by OSHPD); awarded in March 2014 – establishing ACHBCS as a partner to Bay Area Peer Professional Network (BAPPN)

- Actively provided consultation and assistance to Office of Statewide Planning and Development (OSHPD) in planning for this year's statewide WET 5-year plan throughout FY 2013/2014

- Academic and Employment Resource Expo (May 2014, 65 participants; 10 organizations), collaborative partnership with POCC

- Provided Family Leadership and Family Advocate Training Programs through the Family Education Resource Center (FERC).

- Implemented annual BEST Now! Consumer Employment Training Program with 6 month internships: 21 graduates.
- Organized two outreach meetings to promote BCC Public and Human Services Programs with BCC & BEST Now & Pool of Consumer Champions (POCC) members for 20 individuals.
- Partnered with BHCS Consumer Empowerment Team & Mental Health Association of San Francisco (MHASF) in their application for Peer Personnel Preparation RFP released by OSHPD.
- The purpose of this grant was to increase the number of peer specialists in public mental health and to develop career pathways and educational training(s) for peer specialists. MHASF was awarded the grant and developed a new organization: Bay Area Peer Professional Network (BAPPN) of which we are a partner.
- Participated in the interviewing process for the new Project Manager for the Regional Partnership WET program.
- Assisted with planning the Bay Area County Behavioral Health and Human Resources Forum, a collaborative event organized by the Regional Partnership WET program.
- Implemented Academic and Employment Resource Expo, in collaboration with POCC, to provide resources regarding their services and trainings. There were 65 participants, and 10 organizations.

Consumer and Family Training, Education and Employment continued…
FY 15/16, 16/17 Plans:

- For FY 15/16 Estimated 148 consumer providers and 94 family employees in Alameda County and community based organizations (CBO)
- For FY 16/17 Estimated 152 consumer providers and 98 family employees in Alameda County and community based organizations (CBO)
- Provide employment opportunities list serve for consumers and family members
- Convene ongoing Consumer & Family Work Group meetings to learn, discuss and problem solve consumer and family employment content & issues
- Continued development of “learning collaborative” for managers who are working with consumer and family employees to provide technical assistance and support to managers, culminating in establishing and implementing an ongoing series for all three consecutive fiscal years
- Provide Supervisorial Training: “Welcoming and Partnering with Consumer Family Employees” – re-evaluate for next two consecutive years
- Provide Family Leadership and Family Advocate Training Programs through the Family Education Resource Center (FERC)
- Implement annual BEST Now! Consumer Employment Training Program with 6 month internships

- Work with ACBHCS Consumer Empowerment Team & MHASF for their grant with Bay Area Peer Professional Network (BAPPN) awarded in March 2014 for Peer Personnel Preparation (to provide necessary information and other needs)
- Develop and implement an educational & supportive skill building series for consumers currently employed in the mental health field to support employment retention and growth.
- Provide job readiness events "Dress for Success" Clothing Boutique Exchange
- Academic and Employment Resource Expo/Fair– each fiscal year/as needed
- Implementation of Peer Navigator Pilot Program by FY 16/17

3. Training & Technical Assistance

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 13/14 Outcomes, Impact & Challenges:

- Provided over 75 targeted training events and more than 200 Continuing Education (CE) credits for diverse disciplines including LCSWs, MFTs, CAADAC, RNs, psychologists, MDs and registering more than 2,000 participants
- Continued to provide required CE credits and Continuing Medical Education (CME) credits annually for licensed providers and physicians employed in County and CBO sites including legal/ethical updates, clinical supervision (general) and clinical supervision for interns
- Continued to provide community trainings on Mental Health First Aid
- Continuing to develop and implement county wide training on cultural and linguistic competencies to enhance culturally responsive services
- Continuing technical assistance on helping to identify training needs and implement training activities for four systems of care (Children's, Transition Age Youth, Adult and Older Adult) and started to offer specialized training specifically to our Alcohol/Other Drug system of care

D. WORKFORCE, EDUCATION & TRAINING PROGRAM SUMMARIES

- Implemented an online registration system in collaboration with the Alameda County Training and Education Center that enables participants to register independently online, have record of their training activities on an official transcript and enables their supervisors to track past, present and future training activities for their staff and for Training Unit staff to automatically prepare participant rosters, certificates of attendance and continuing education credits and other reports

- Collaborated with the Innovations (INN) Learning Conference staff for Round 2 of grantee activities to plan and implement an INN Learning Conferences in February 2014 for African American-focused programs

- Provided a required legal course for staff of ACBHCS Alcohol/Other Drug providers

- Provided a pilot training for supervisors and direct line staff on Motivational Interviewing

- Offered follow up activities for staff of primary care clinics on five EBPs (listed in FY2012/2013) including mentoring sessions and reviews of secure digital recordings of clinicians utilizing EBP in their work with clients

Training & Technical Assistance continued…
FY 14/15 Progress Report:

- Offered or collaborated on a total of 60 training activities focused on behavioral health focused topics including legal and ethical issues, clinical documentation, neuro-developmental issues, substance use disorders, eating disorders, trauma-informed care, Mental Health First Aid and evidence-based practices (EBP) including motivational interviewing, working with families with EBP, SBIRT (Screening, Brief Intervention, and Referral to Treatment), ASAM (American Society of Addiction Medicine) Criteria and more. In addition, 6 Continuing Medical Education (CME) training activities were offered our psychiatric and medical/clinical staff including recovery strategies for medical and behavioral health care, the role of religion and spirituality in psychiatry, primary care and mental health integration and more

- More than 2,105 Alameda County staff from county units and community-based organizations were trained in 2014 and more than 255 continuing education credits were offered for our licensed staff (LCSWs, MFTs, LPCCs, RNs, substance use disorder staff, psychologists and physicians) to renew their licenses and credentials

- Expanded our CME dinner programs to more physicians and medical/clinical care staff on a variety of medical/clinical topics related to behavioral health care specifically and the integration of primary care and behavioral health care services

- Provided consultation with our consumer organizations, the Pool of Consumer Champions (POCC) and Peers Envisioning and Engaging in Recovery Services (PEERS), on an annual regional conference focused on wellness, recovery and resiliency

- Collaborated with the Greater Bay Area Mental Health and Education Workforce Collaborative and county educational organizations and schools to provide two - one day conferences for high school students to have an introduction to behavioral health careers

- Developed a pilot mental health paraprofessional training program for unserved and underserved new and emerging immigrant and refugee communities. This program will be an extension of the existing MHSA PEI-funded API Connections program which serves unserved Asian and Pacific Islanders

- Implemented and managed a “Request for Proposal” process with Alameda County General Services Agency for training services related to offering clinical training on evidence-based practices including Motivational Interviewing, Seeking Safety, Cognitive Behavioral Treatment and more. The RFP was for a three year, $90,000 per year ($270,000 total) contract with multiple vendors. The process was completed in June 2015 and scheduling for training is in process

- Managed a continuing and regular meeting (8 x per year) of a 17 member Training Committee composed of representative staff from county units and community-based organization. The

Training Committee advises the Training Officer on training activities related to both clinical and administrative staff throughout our system

FY 15/16, 16/17 Plans:

Continue to:

- Provide targeted training and providing CE credits for registered BHCS participants (both County and CBO staff)
- Provide required CE credits and CME classes annually for licensed providers and physicians employed in County and CBO sites
- Provide trainings on Mental Health First Aid (general version) and begin to offer a youth version during the fiscal year
- Focus on providing more specialized courses for staff of ACBHCS Alcohol/Other Drug providers
- Provide more training for BHCS supervisors and direct line staff on Motivational Interviewing (MI) and other evidence-based practices (EBP) including Seeking Safety
- Offer more training for staff of primary care clinics on EBPs and other topics related to the integration of care for primary care and behavioral health settings including MI and Seeking Safety

And in addition to above in FY15/16 :

- Provide primary care providers advanced training in “primary care psychiatry” in collaboration with the UC Davis Train New Trainers (TNT) Primary Care Psychiatric Fellowship Program
- Expand our training activities to focus specifically on our Alcohol and Other Drug System of Care with subjects including EBP, documentation and charting skills and more
- Continue to collaborate with the Greater Bay Area Mental Health and Education Workforce Collaborative and county educational organizations and schools to provide a one day conference for high school students to have an introduction to behavioral health careers in March 2016.Continue to provide consultation with our consumer organizations, the Pool of Consumer Champions (POCC) and Peers Envisioning and Engaging in Recovery Services (PEERS), on an annual regional conference focused on wellness, recovery and resiliency in June 2016
- Continue to collaborate with the Innovations (INN) Learning Conference staff for Round 3 of grantee activities to plan and implement two INN Learning Conferences; scheduled for January 22, 2016 for Isolated Adults/Older Adults grants and March 24, 2016 for LGBTQI2-S grants

And in addition to above in FY16/17:

D. WORKFORCE, EDUCATION & TRAINING PROGRAM SUMMARIES

- Begin to offer more trainings focused on EBPs throughout our behavioral health system including motivational interviewing and change; Seeking Safety; and Cognitive Behavioral Therapy (CBT)
- Reapply for reauthorization to provide Continuing Medical Education (CME) credits for physicians and other medical staff through the Institute of Medical Quality

4. Internship Program

D. WORKFORCE, EDUCATION & TRAINING PROGRAM SUMMARIES

Program Description: Coordinates academic internship programs across the ACBHCS workforce. Meets with educational institutions to publicize internship opportunities and provides training to clinical supervisors and student interns.

FY 14/15 Progress Report:

- Conducted outreach to county-operated programs and contracted, community-based organizations to update and increase number of trainees/intern opportunities available within BHCS system
- 200 graduate students interned in both county-operated programs and community -based organizations
- Hired new Internship Coordinator in August 2014
- Launched third round of Graduate Intern Stipend Program in August 2014 with a focus on interns across system, including behavioral health interns in primary care settings
- Developed and offered orientation to graduate student interns on BHCS System of Care. Provided guidance on how to be a successful BHCS intern as past interns from various Children's System of Care (CSOC) programs shared their experience and stories
- Offered trainings to twelve graduate student interns on Cognitive Behavior Therapy with Youth, Mindfulness Training, Motivational Interviewing, Working with Schools
- Continued to develop and implement the Psychiatric Nurse Practitioner (PMHNP) internship program in collaboration with the University of California San Francisco (UCSF), School of Nursing (SON)
- Outreached to select County clinic managers and community based organization (CBO) program directors to promote PMHNP program, identify interest, and address capacity issues
- Developed new placement sites and identified preceptors to provide supervision to students
- BHCS is currently providing clinical supervision to six Psychiatric Mental Health Nurse Practitioner (PMHNP) students at the Oakland Community Support Center, Eden Children's Services and Criminal Justice Mental Health Services/Conditional Release Program (CONREP). UCSF, SON, will reimburse BHCS for the actual number of supervisor staff hours through the Education Capacity Building OSHPD grant
- Conducted a workforce employment survey among BHCS Graduate Intern Stipend Awardees (recruitment strategy) to find out how many of them are currently employed within Alameda County in a behavioral health career. Data from awardees was collected from the 2011/12 - 2014/15 cycles. Of the 108 awardees, 46% responded. Of those, 48% are currently working in Alameda County. Awardees represent the ethnic and linguistic diversity within Alameda County

- Developed memorandum of understanding with San Jose State University (SJSU), Social Work Program
- Created and developed Intern Onboarding Procedural Manual to provide a reference tool and resource guide to supervisors and expedite the onboarding process

FY 15/16, 16/17 Plans:

- Continue to manage and update the Intern onboarding manual as needed
- Continue to manage and enhance the Graduate Intern Stipend Program
- Launch Graduate Intern Stipend Program
- Plan and implement an undergraduate career pathways program
- Continue collaborating with UCSF on developing the PMHNP student internship program
- Continue coordination and collaboration with various administrative entities to complete development of internship agreements with Cal State University East Bay, San Francisco State University and University of California, Berkeley, Social Work Programs
- Continue providing administrative functions and technical support to CSOC with the addition of the Adult System of Care (ASOC) and CONREP

5. 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 ACBHCS workforce.

FY 13/14 Outcomes, Impact & Challenges:

BHCS has developed and implemented the following activities:

- Planned, organized, and co-hosted the first Bright Young Minds (BYM) conference on March 16, 2015, in collaboration with Alameda County Health Pipeline Partnership (ACHPP), California Institute for Behavioral Health Solutions (CiBHS), Family Education Resource Center (FERC), Oakland Unified School District (OUSD), and Merritt College. It was a ground-breaking conference and more than 140 high school students from diverse and under-represented communities participated to explore behavioral health care career options

D. WORKFORCE, EDUCATION & TRAINING PROGRAM SUMMARIES

- Second Bright Young Minds (BYM) conference planned and co-hosted on November 4, 2015 at Samuel Merritt University, in collaboration with ACHPP, CiBHS, FERC, and OUSD. 160 students from diverse ethnic and under-represented communities participated in exploring behavioral health care career options

- June – July 2015: Provided behavioral health workshops to 30 high school and college students at the Mentoring in Medicine and Science (MIMS) summer program. During their seven week training and internship program, WET coordinated activities, such as workshops in various mental health topics, a panel presentation, "speed mentoring" with a variety of behavioral health care professionals, and site visits to CBO service sites

- Collaborated with Berkeley City College (BCC), Public and Human Services Program, on the Peer Personnel Training and Placement grant. BCC as the primary applicant received the grant for $500, 000 for training and placement of people with lived experience

- BCC will continue to teach wellness, recovery and resiliency focused curriculum- Introduction to Behavioral Health (HUSV 117) which was developed and written by BHCS

- The WET Manager served on California State University East Bay's School of Social Work Advisory Committee and Berkeley City College's Public and Human Services Advisory Committee

Educational Pathways continued…
FY 14/15 Progress Report:

- Developed and provided a three unit curriculum on Co-Occurring Conditions to BCC for curriculum committee's review and approval
- BCC integrated the Co-Occurring Conditions curriculum into their existing health education classes
- The curriculum is currently being reviewed by BCC and the Peralta Community College curriculum committee and will be forwarded to the State Chancellor's office for final review and approval
- Planning and developing a Third Bright Young Minds (BYM) conference for March 23, 2016 at Cal-State East Bay to expose and encourage economically and educationally disadvantaged and or underrepresented high school students to pursue careers in behavioral health. Collaborators are ACBHCS, ACHPP, CiBHS, FERC, Cal State East Bay STEM Program, and Hayward Unified School District. Target student participation is 150 from the Hayward, San Leandro, San Lorenzo, and Castro Valley Unified School
- Hosting a planning group to discuss ideas and strategies to provide undergraduate students an opportunity to get an in-depth understanding about mental/behavioral health careers. Our goal is to develop a pilot project to be offered in summer 2016 to engage undergraduate students who are pursuing education in the fields of Human Services, Sociology, Psychology, Social Work or Nursing
- Continued peer mentoring and supported education for Transitional Age Youth (TAY) at Peralta Colleges
- The WET Manager continued to serve on California State University East Bay's School of Social Work Advisory Committee, Berkeley City College's Health and Human Services Advisory Committee, and the State Licensed Mental Health Service Provider Education Program

FY 15/16, 16/17 Plans:

- Continue implementing Mental Health High School Career Pathways Project including organizing additional conferences on introducing high school students to behavioral health careers
- Continue partnership and coordination with Berkeley City College on their Public and Human Services program to increase access for our consumers and family members entering community college
- Offer co-occurring conditions classes at BCC, Public and Human Services program

6. Financial Incentives 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 ACBHCS and to graduate interns placed in ACBHCS and contracted community-based organizations, and who are linguistically and or culturally able to serve the underserved and unserved populations of the County.

FY 13/14 Outcomes, Impact & Challenges:

BHCS has developed and implemented the following activities:

- BHCS has partnered with OSHPD to implement the State Mental Health Loan Assumption Program (a vital retention strategy)
- BHCS updated the existing eligibility criteria for the Loan Assumption Program, with an emphasis on increasing workforce diversity and language capacity as well as addressing hard to fill positions and skill sets
- 38 clinicians in County and contract Community Based Organization (CBO) settings received up to $10,000 towards their outstanding student loans
- Provided financial support for Federally Qualified Health Centers (FQHCs) to hire behavioral health clinicians
- Hired County-funded psychiatrists to offer behavioral health consultation

Financial Incentives Program continued…
FY 14/15 Progress Report:

- Conducted a workforce employment retention survey among Alameda County MHLAP awardees from 2009 – 2014 cycles. The goal was to find out how many of them retained employment within Alameda County in a behavioral health career. Of the 106 awardees, 62% responded. Of those, 89 % are currently working in Alameda County. Awardees represent the ethnic and linguistic diversity within Alameda County

- Provided three MHLAP technical assistance application workshops to county and CBO staff

- Continue to provide employment verification support to applicants and serve as the liaison between applicants and State MHLAP staff

- 24 clinicians in County and contract Community Based Organization (CBO) settings received up to $10,000 towards their outstanding student loans

- BHCS Graduate Intern Stipend Program (recruitment strategy)
    - Launched and administered the third round of the stipend program in August 2014 and the fourth round in August 2015 with a focus on interns across system.
    - Awarded 35stipends in the amount of $6,000 for 720 internship hours. Of the 35 awardees, 74% represent the diverse communities of Alameda County

FY 15/16, 16/17 Plans:

- BHCS will continue to partner with OSHPD to implement the State Mental Health Loan Assumption Program (a vital retention strategy)

- Launch fifth round of the BHCS Graduate Intern Stipend Program in August 2016

- Explore the feasibility of participating in the federally designated California Health Professional Shortage Area (HPSA) State Loan Repayment Program (SLRP)

Alternatives to AB1421

Public Comment	Response
Two years ago in February the BOS approved nine of ten recommendation and just last November approved AOT. Where are all of those programs, the other nine?	See Table I. below

TABLE I. Progress on Alternatives to AB1421

Initial Recommendations	Progress To Date
Recommendation #1: The In Home Outreach Team (IHOT) will provide home or community-based support and education to clients/consumers, family members and caregivers. Modeled after San Diego County's successful pilot, IHOT focuses on outreach, engagement and support and links participants to services and community resources.	*Program researched and developed. Request for Proposals released and responses due April 2016. Awards scheduled for July 2016.*
Two Transition Age Youth (ages 18-24) programs included in the initial recommendations, received funding from the State's MHSA Oversight and Accountability Commission Crisis Triage Grants. The $2.6 million award will cover the costs of these programs for three years. BHCS recently completed the RFP process, selected a provider for these programs and is submitting a letter to the Board of Supervisors seeking funding approval for the programs outlined below: • **The Street Youth Outreach Team [Recommendation #2]** will meet and engage young people "where they're at" in the community or in the hospital, and will help link them to services and treatment. • **The TAY Intensive Case Management Program [Recommendation #7],** will work with youth who are difficult to engage, require assistance with maintaining their activities of	• *Street outreach program is implemented by Bay Area Community Services, Hope Intervention Program.* • *TAY Intensive case management is in development by Radawn Alcorn, Interim TAY System of Care Director.*

daily living and would benefit from these services.	
Recommendation #3: The BHCS Transition Age Youth System of Care plans to expand Multifamily Groups to support family members of youth who are not engaged or participating in their treatment.	*In development by Rosa Warder, Family Empowerment Manager, Radawn Alcorn, Interim Crisis Services Manager and Paul Takayanagi, Training Director.*
Recommendation #4: BHCS plans to release a Request for Proposal (RFP) for a Post Crisis Peer Support Program for consumers being discharged from John George Psychiatric Pavilion, based on promising practices from MHSA Innovation Grants Round 1.	*Program design will integrate #4 and #5: "Peer Navigator Program" to include post-crisis support and primary care linkages.*
Recommendation #5: The Peer Navigator Program will offer individual peer support to clients/consumers during care transitions between different levels of care and provide linkages to primary and behavioral health services and to community resources.	
Recommendation #6: BHCS has hired a Critical Care Manager for John George Psychiatric Pavilion (JGPP) who started work in October 2014. This manager will work with JGPP staff to identify BHCS services and community resources for clients/consumers in Psychiatric Emergency Services (PES) or the hospital and divert individuals from the PES to community settings.	*Critical Care Manager hired.*
Recommendation #8: The STEPS Adult Intensive Case Management Program to address a broader target population that includes clients/consumers experiencing early episodes of mental illness in the hospital and to increase the flow of clients/consumers to less restrictive community-based services.	*Augmentation to provider contract executed.*

Recommendation #9: The Forensic Assertive Community Treatment (FACT) Team to address a broader target population that includes clients/consumers experiencing early episodes of mental illness while incarcerated and to increase the flow of clients/consumers to less restrictive community-based services. FACT serves persons who have a history of excess utilization of mental health, substance abuse and criminal justice systems in Alameda County and utilizes the ACT model.	*Augmentation to provider contract under negotiation.*

PEI 4. Stigma and Discrimination Reduction Campaign

Public Comment	Response
Stigma Reduction…if we are spending so much money in stigma reduction one of the outcomes that I would hope more people want to come forward and get help that they would not otherwise do. If we're spending all these money how are you measuring whether or not anybody are even coming forward and getting help that they would not otherwise got help?	The MHSAOAC has approved and will require in future reports outcome measures that include the number of referrals to treatment programs that prevention and early intervention programs make.

ATTACHMENT B

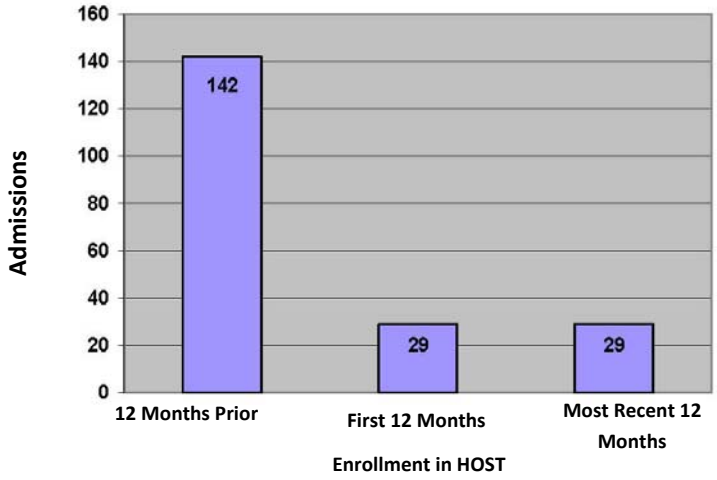
Quality Social Rehabilitation Services Since 1971

Bonita House, Inc.

HOST
Adult Full-Service Partnership Program Outcomes
June 2007 through December 2014
Based on a Total of 138 Partners

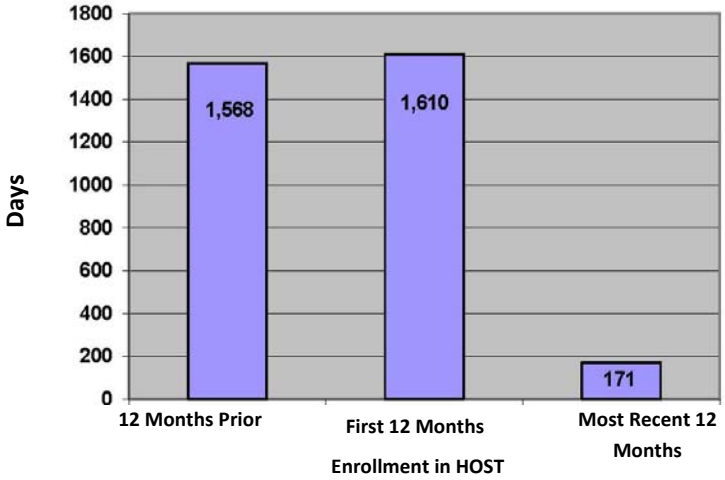
WELLNESS • RECOVERY • RESILIENCE

New Psychiatric Hospital Admissions



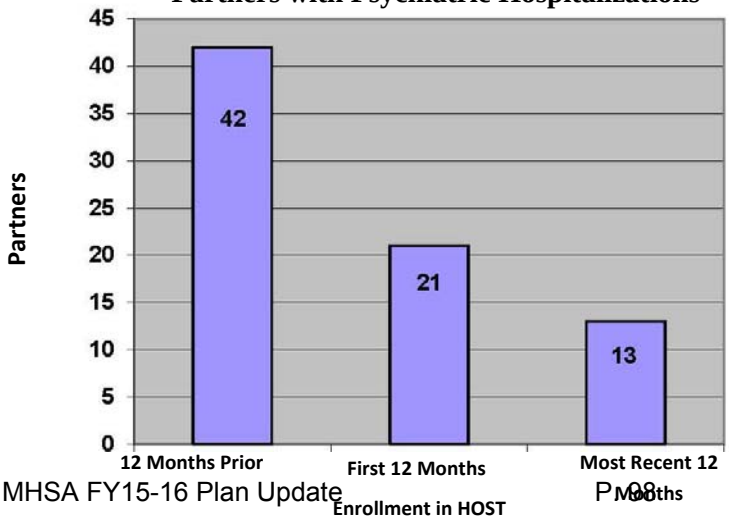
79.6% Decrease in the Number of New Psychiatric Hospital Admissions from 12 Months Prior to Enrollment in HOST Compared to Most Recent 12 Months of Enrollment as of 12/31/2014.

Psychiatric Hospital Days



89.1% Decrease in the Number of Psychiatric Hospital Days from the 12 Months Prior to Enrollment in HOST Compared to the Most Recent 12 Months of Enrollment as of 12/31/2014.

Partners with Psychiatric Hospitalizations



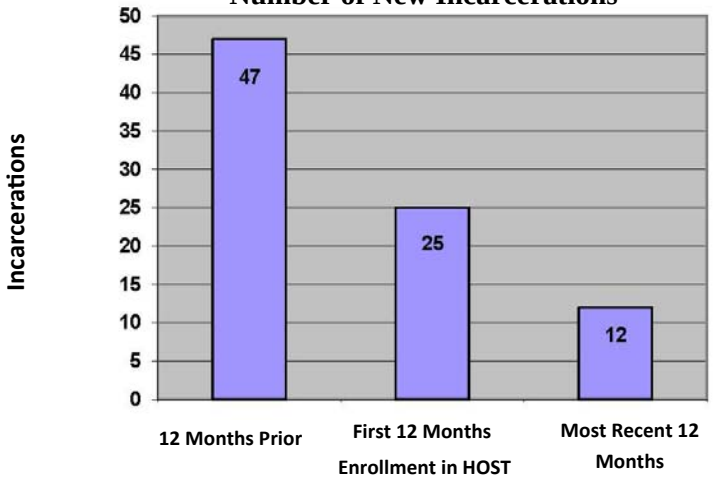
69.0% Decrease in the Number of Partners with Psychiatric Hospitalizations from the 12 Months Prior to Enrollment in HOST Compared to the Most Recent 12 Months of Enrollment as of 12/31/2014.

ATTACHMENT B

Bonita House, Inc.
HOST
Adult Full-Service Partnership Program Outcomes
June 2007 through December 2014
Based on a Total of 138 Partners

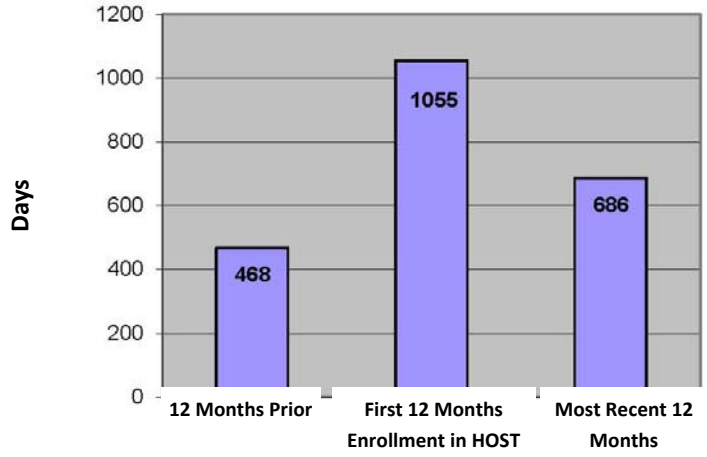
WELLNESS • RECOVERY • RESILIENCE

Number of New Incarcerations



74.5% Decrease in the Number of New Incarcerations from 12 Months Prior to Enrollment in HOST Compared to Most Recent 12 Months of Enrollment as of 12/31/2014.

Number of Incarceration Days

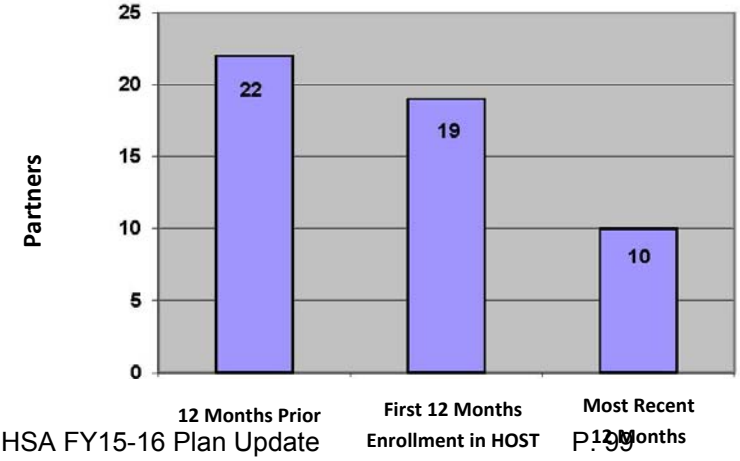


46.6% Increase in the Number of Incarceration Days for Partners from the 12 Months Prior to Enrollment in HOST Compared to the Most Recent 12 Months of Enrollment as of 12/31/2014.

NOTE: In the most recent 12 months of enrollment one partner accounted for almost one-half of the incarceration days (328).

Without this outlier, there was a ***16.9% Reduction in the Number of Incarceration Days Among Partners.***

Number of Partners Incarcerated



54.5% Decrease in the Number of Partners Incarcerated from 12 Months Prior to Enrollment in HOST Compared to the Most Recent 12 Months of Enrollment as of 12/31/2014.

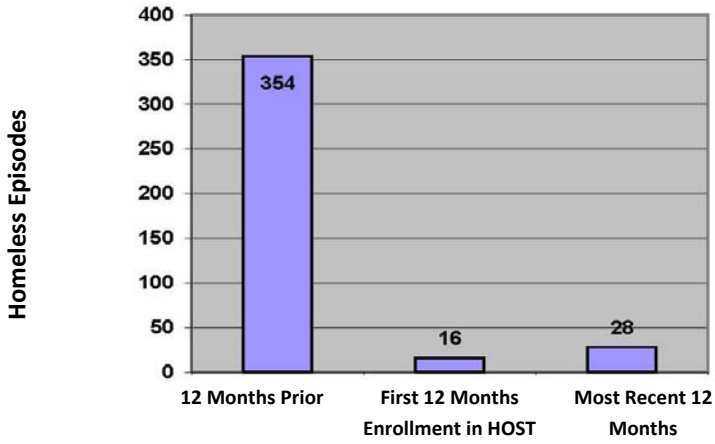
ATTACHMENT B

Bonita House, Inc.
HOST
Adult Full-Service Partnership Program Outcomes
June 2007 through December 2014
Based on a Total of 138 Partners

Quality Social Rehabilitation Services Since 1971

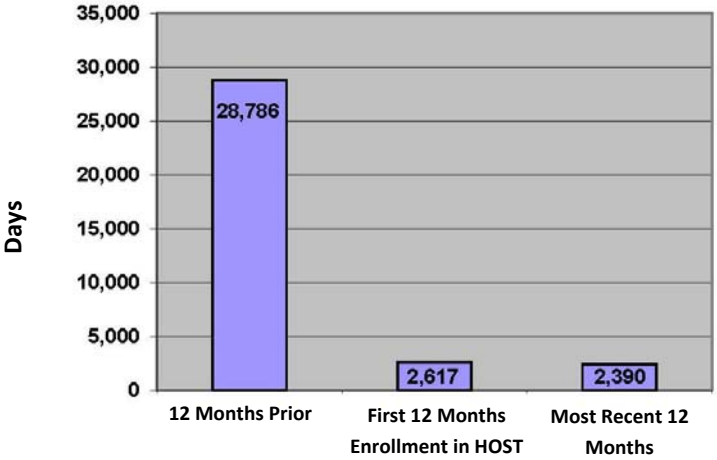
WELLNESS • RECOVERY • RESILIENCE

Number of New Homeless Episodes



92.1% Decrease in the Number of Homeless Episodes Among Partners from the 12 Months Prior to Enrollment in HOST Compared to the Most Recent 12 Months of Enrollment as of 12/31/2014.

Number of Days of Homelessness



91.7% Decrease in the Number of Days of Homelessness Among Partners from the 12 Months Prior to Enrollment in HOST Compared to the Most Recent 12 Months of Enrollment as of 12/31/2014.

Number of Partners Experiencing Homelessness

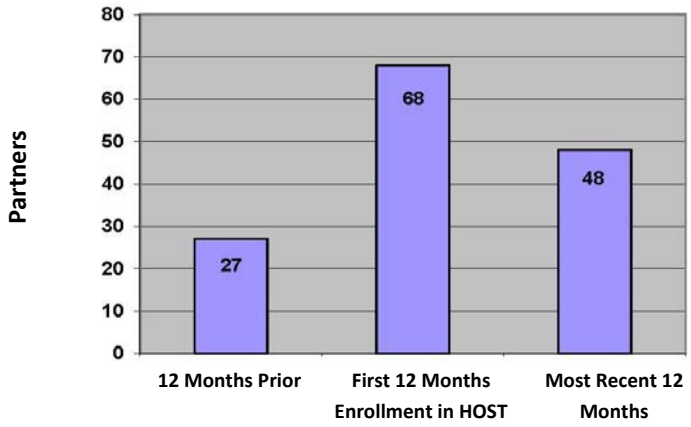
85.6% Decrease in the Number of Partners who Experienced Homelessness in the 12 Months Prior to Enrollment in HOST Compared to the Most Recent 12 Months of Enrollment as of 12/31/2014.

Quality Social Rehabilitation Services Since 1971

Bonita House, Inc.
HOST
Adult Full-Service Partnership Program Outcomes
June 2007 through December 2014
Based on a Total of 138 Partners

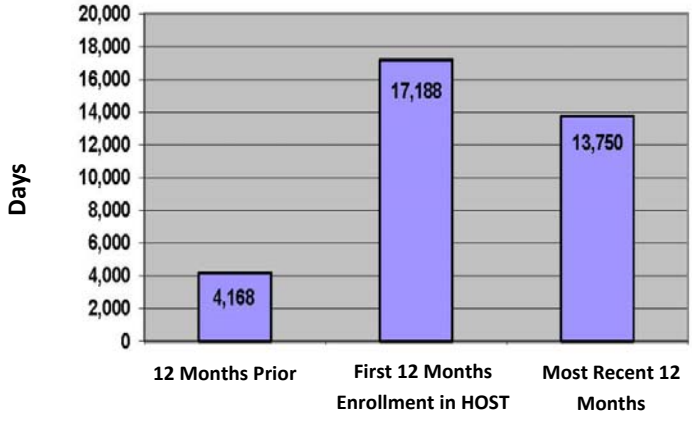
WELLNESS • RECOVERY • RESILIENCE

Number of Partners Employed



77.8% Increase in the Number of Partners Employed from the 12 Months Prior to Enrollment in HOST Compared to the Most Recent 12 Months of Enrollment as of 12/31/2014.

Number of Days of Employment



229.9% Increase in the Number of Days of Employment Among Partners from the 12 Months Prior to Enrollment in HOST Compared to the Most Recent 12 Months of Enrollment as of 12/31/2014.

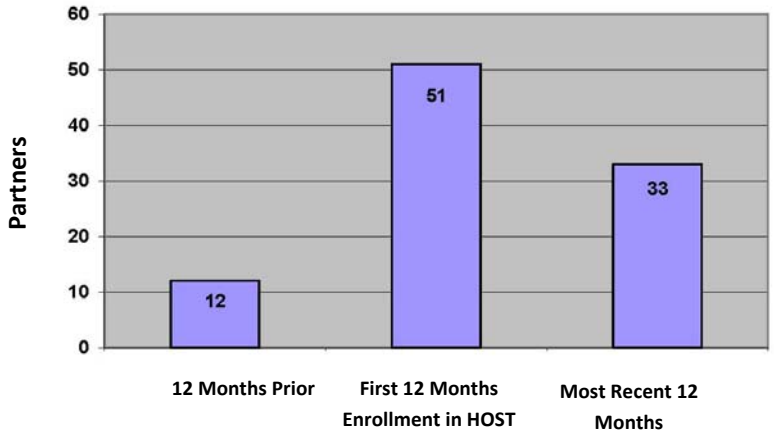
ATTACHMENT B

Bonita House, Inc.
HOST
Adult Full-Service Partnership Program Outcomes
June 2007 through December 2014
Based on a Total of 138 Partners

Quality Social Rehabilitation Services Since 1971

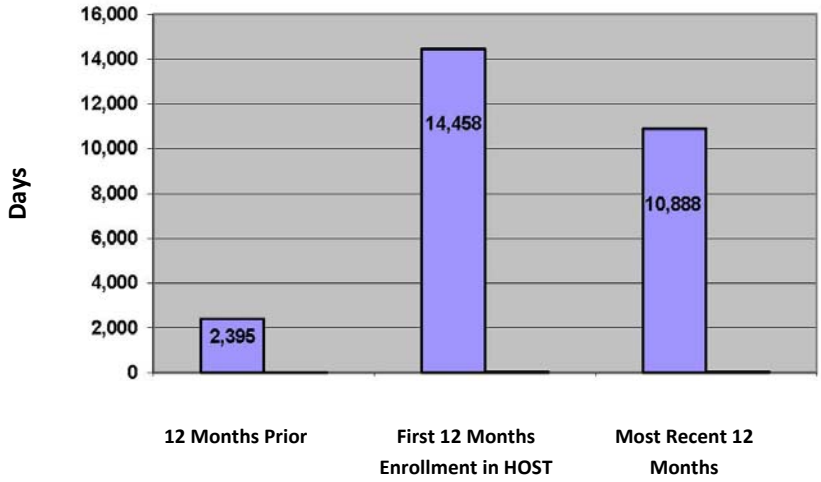
WELLNESS • RECOVERY • RESILIENCE

Number of Partners in School or Taking Classes



175.0% Increase in the Number of Partners in School or Taking Classes from the 12 Months Prior to Enrollment in HOST Compared to the Most Recent 12 Months of Enrollment as of 12/31/2014.

Number of Days Partners in School or Taking Classes



354.6% Increase in the Number of Days Partners in School or Taking Classes from the 12 Months Prior to Enrollment in HOST Compared to the Most Recent 12 Months of Enrollment as of 12/31/2014.

ATTACHMENT B

Bonita House, Inc.
HOST
Adult Full-Service Partnership Program Outcomes
June 2007 through December 2014
Based on a Total of 138 Partners

Psychiatric Hospitalization

New Psychiatric Hospital Admissions:	
12 Months Prior to Enrollment	142
First 12 Months of Enrollment	29
Most Recent 12 Months Post Enrollment	29
Decrease in New Psychiatric Hospital Admissions:	**79.6%**

Psychiatric Hospital Days:	
12 Months Prior to Enrollment	1,568
First 12 Months of Enrollment	1,610
Most Recent 12 Months Post Enrollment	171
Decrease in Psychiatric Hospital Days:	**89.1%**

Partners with Psychiatric Hospitalizations:	
12 Months Prior to Enrollment	42
First 12 Months of Enrollment	21
Most Recent 12 Months Post Enrollment	13
Decrease in Partners with Psychiatric Hospitalizations:	**69.0%**

Bonita House, Inc.
HOST
Adult Full-Service Partnership Program Outcomes
June 2007 through December 2014
Based on a Total of 138 Partners

Incarceration

New Incarcerations:	
12 Months Prior to Enrollment	47
First 12 Months of Enrollment	25
Most Recent 12 Months Post Enrollment	12
Decrease in New Incarcerations	**74.5%**

Days Incarcerated With Outlier*:	***With Outlier***
12 Months Prior to Enrollment	468
First 12 Months of Enrollment	1055
Most Recent 12 Months Post Enrollment	686
Increase in Days Incarcerated	**46.6%**

**NOTE: One partner (outlier) accounted for almost half of the incarceration days (328) in the Most Recent 12 Months*

Days Incarcerated Without Outlier*:	***Without Outlier***
12 Months Prior to Enrollment	431
First 12 Months of Enrollment	726
Most Recent 12 Months Post Enrollment	358
Decrease in Days Incarcerated	**16.9%**

**NOTE: One partner (outlier) accounted for almost half of the incarceration days (328) in the Most Recent 12 Months*

Incarcerated Partners:	
12 Months Prior to Enrollment	22
First 12 Months of Enrollment	19
Most Recent 12 Months Post Enrollment	10
Decrease in Incarcerated Partners	**54.5%**

Bonita House, Inc.
HOST
Adult Full-Service Partnership Program Outcomes
June 2007 through December 2014
Based on a Total of 138 Partners

Homelessness

New Episodes of Homelessness:	
12 Months Prior to Enrollment	354
First 12 Months of Enrollment	16
Most Recent 12 Months Post Enrollment	28
Decrease in Episodes of Homelessness	**92.1%**
Days of Homelessness	
12 Months Prior to Enrollment	28,786
First 12 Months of Enrollment	2,617
Most Recent 12 Months Post Enrollment	2,390
Decrease in Days of Homelessness:	**91.7%**
Homeless Partners:	
12 Months Prior to Enrollment	111
First 12 Months of Enrollment	37
Most Recent 12 Months Post Enrollment	16
Decrease in Homeless Partners	**85.6%**

***Homelessness** after enrollment in HOST reflects:*

(1) A small number of partners who are still in their first year of the program and are not comfortable yet with living in housing; and (2) A very few partners who have repeatedly lost housing (due to not paying rent, causing continued disruptions in their building, etc.) and who decline the offer of emergency housing.

ATTACHMENT B

Bonita House, Inc.
HOST
Adult Full-Service Partnership Program Outcomes
June 2007 through December 2014
Based on a Total of 138 Partners

Employment

Employed Partners:	
12 Months Prior to Enrollment	27
First 12 Months of Enrollment	68
Most Recent 12 Months Post Enrollment	48
Increase in Employed Partners:	**77.8%**
Days Employed	
12 Months Prior to Enrollment	4,168
First 12 Months of Enrollment	17,188
Most Recent 12 Months Post Enrollment	13,750
Increase in Days Employed	**229.9%**

***Competitive employment** is defined as any employment placement that is taxable and reported to the IRS. Competitive employment opportunities are jobs that offer above minimum wage and/or medical coverage.*

***Supported employment** is a Substance Abuse and Mental Health Services Administration (SAMHSA) evidence-based practice. Job search process begins immediately after a consumer expresses an interest to return to work and is determined by consumer preference and abilities.*

Education

Partners in School or Taking Classes:	
12 Months Prior to Enrollment	12
First 12 Months of Enrollment	51
Most Recent 12 Months Post Enrollment	33
Increase in Partners in School or Taking Classes	**175.0%**
Days in School or Taking Classes:	
12 Months Prior to Enrollment	2,395
First 12 Months of Enrollment	14,458
Most Recent 12 Months Post Enrollment	10,888
Increase in Days in School or Taking Classes	**354.6%**

CRISIS SUPPORT SERVICES
of Alameda County

Crisis Line Program
Year End Report
FY2014-2015

Connecting People in Need
With People who Care

Table of Contents

Suicidal feelings are among humanity's worst forms of suffering: the response we give is a call to our greatest humanness.
- Will Hall, mental health advocate, counselor, writer, and teacher

Special Thanks to Kristina Komori, Lauren Musante, Will Gutierrez, Daniel Bermeo, Tatille Jackson and Tina Mornard for gracing the cover. Photo Credit: Will Gutierrez and Binh Au

In April, we were honored to receive an Appreciation Award at the Sangam of the East Bay dinner and fundraising event. Sangam of the East Bay is a community of Fijians of South Indian descent based in Hayward. I am pictured here with Arvin Reddy, the President of the organization. He had made grab bags with referrals and suicide prevention buttons, and he prepared a short presentation describing warning signs of suicide and depression and tips on how to get help for yourself and your loved ones. When she heard what he was planning on talking about at the event, his mother almost chose not to attend; that is mental health stigma in action. There was uncomfortable silence and pointed looks that evening. In their culture, you are not supposed to talk about problems or say the "S word." Arvin opened the doors to conversation for his community. This was a courageous and necessary step. Breaking the silence can potentially save lives.

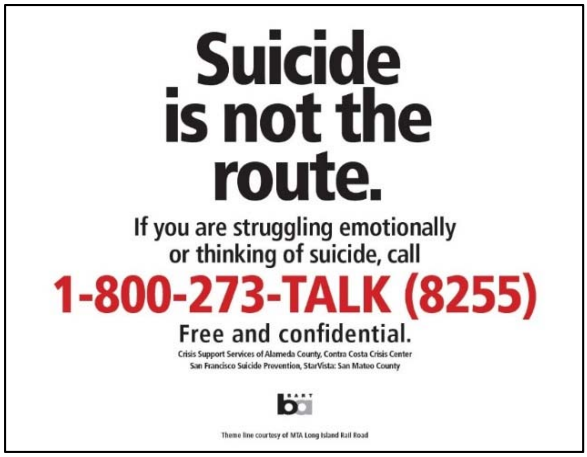
There was a family there who had lost a loved one to suicide last year. They came the night before to help decorate and set up for the party. They wore the buttons that said, "A World Without Suicide." Even though they did not talk about their experience that night or during the party, I'd like to think they found a little comfort knowing they were part of a community and that they were not alone in their grief and loss. The Crisis Line Program is committed to working towards building a world without the tragic experience of suicide.

CSS responded to **60,734 calls** on our three Alameda County call lines. (24 hour Crisis Line, Alameda County Behavioral Health ACCESS Afterhours Lines, National Suicide Prevention Lifeline.) CSS serves as a safety net for people who may not be connected to services. We work to link people in crisis to Alameda County resources, including social services, homeless and housing resources, drug and alcohol resources, Sausal Creek, family advocacy programs like FERC and NAMI, domestic violence and physical assault and rape resources, and Alameda County Behavioral Health Care Services.

We rely heavily on our volunteer workforce. For the Crisis Line Program alone **185 volunteers and interns** contributed over **18,720 hours** on the crisis lines this year. This is a tremendous cost savings to the county. It is difficult to put a dollar amount on the service provided by our volunteers. As an estimate, if we were to pay our volunteers $17.00/hour, it would equate to roughly $397,800 for their service. We had a very successful recruitment effort this year, hiring and training **83 community volunteers and counseling interns**.

This year, CSS renewed our 5 year accreditation by the American Association of Suicidology (AAS). Our examiners commented that, "The agency demonstrates a culture of respect for one another, as well as the clients/callers who utilize their services. They are well integrated in their local behavioral health system as well as the San Francisco Bay Area network of crisis centers." The examiners reviewed our administrative and organizational structure, volunteer screening and training

program, services in life threatening situations, ethical standards, community integration and program evaluation. We are proud to operate within the best practice standards established by the AAS. As members of the National Suicide Prevention Lifeline, we must also work within best practice standards. We collaborate with other crisis centers nationwide and attend webinars to stay up to date with current theories and practices in the realm of suicide prevention and mental health wellness and recovery.



This year was a big year for suicide prevention in the media. Robin Williams' death sparked a national conversation about mental health challenges and suicide and two films about suicide prevention won Academy Awards. There was a small increase in call volume on the National Suicide Prevention and a significant increase on the ACCESS afterhours line in the months immediately following Robin William's death. In response to recent suicide deaths and suicide attempts, BART launched its suicide prevention campaign in April with signage in the BART stations. Greater public awareness about suicide prevention will create a greater demand for services. Our crisis counselors will be there 24/7 to take the call, offer warmth and compassion, and help our community members work through their crisis.

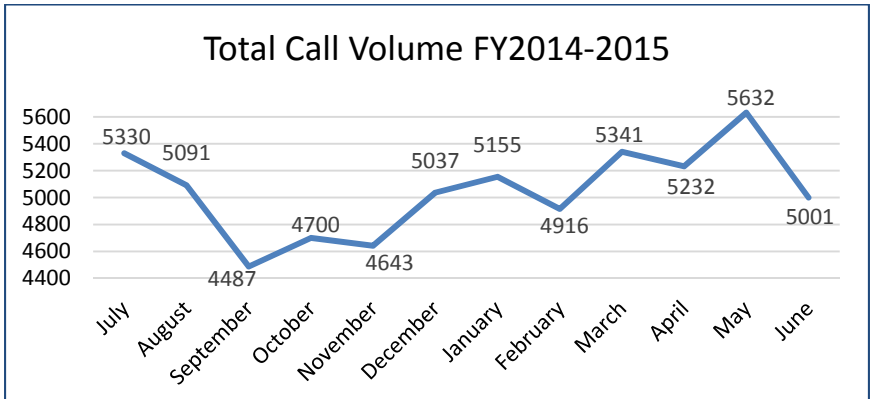
Sincerely,

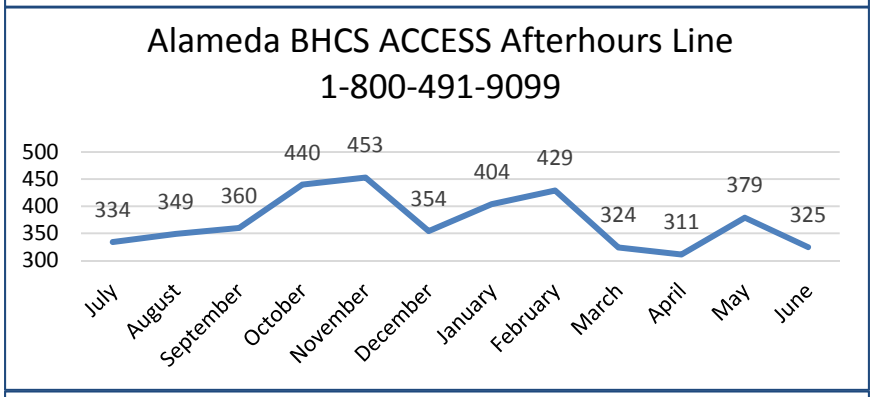
Binh Au
Crisis Line Program Director
August 2015

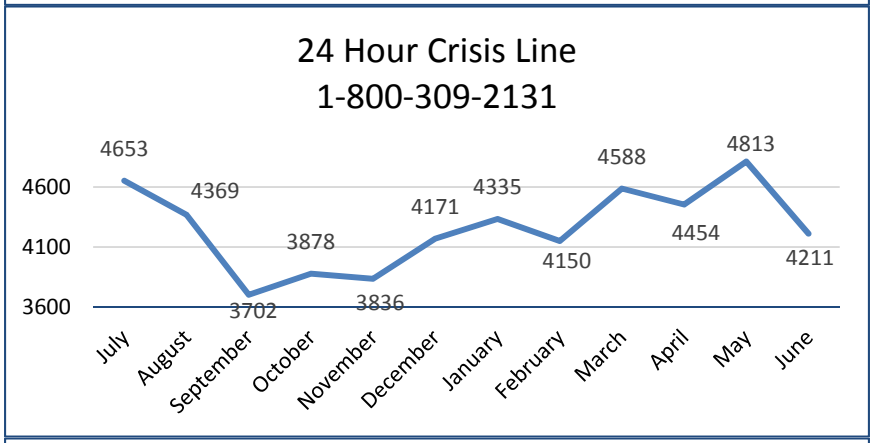
Our Life Saving Mission To reach out and offer support to people of all ages and backgrounds during times of crisis, to work to prevent the suicide of those who are actively suicidal, and to offer hope and caring during times of hopelessness.

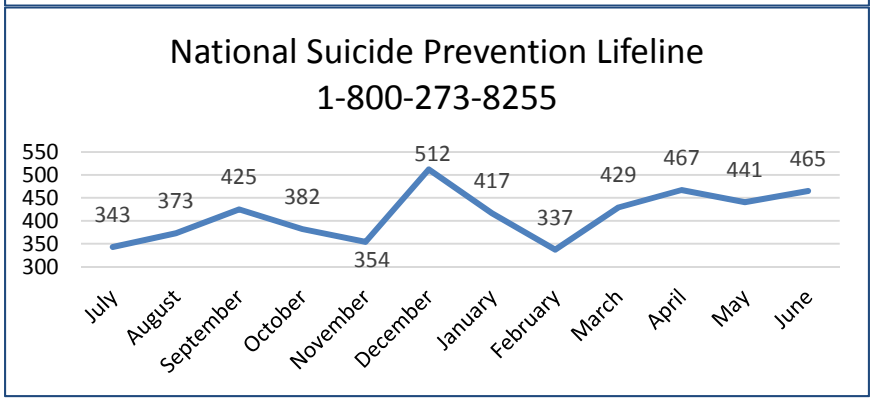
Acknowledgement

Our good work would not be possible without the dedication of our crisis line staff and volunteers. We have a poster in our crisis line call room that says "Volunteers Are the Heart of CSS" and we whole-heartedly believe it.









Total Call Volume
60,734 calls

BHCS ACCESS Afterhours
4,462 calls

24 Hour Crisis Line
51,158 calls

National Lifeline
4,944 calls

Total Crisis Line Volunteers/Interns
185 people

Total NEW Volunteers/Interns
83 people

Total Volunteer Hours
18,720 hours

Total Volunteer Training Class Hours
3,055 hours

Total Number of Returning Callers

Returning callers are people who have called two or more times in a given month. This data was calculated per month, and so it is duplicated. The same person, who is a returning caller in one month, can be a returning caller in another month, so that person is counted twice.

	Repeat Calls	Total Calls	Percentage
July 2014	2,977 calls	5,330 calls	55.9%
Aug 2014	2,717 calls	5,091 calls	53.4%
Sept 2014	2,448 calls	4,487 calls	54.6%
Oct 2014	2,275 calls	4,700 calls	48.4%
Nov 2014	2,384 calls	4,643 calls	51.3%
Dec 2014	2,565 calls	5,037 calls	50.1%
Jan 2015	2,533 calls	5,155 calls	49.1%
Feb 2015	2,357 calls	4,916 calls	47.9%
Mar 2015	2,577 calls	5,341 calls	48.2%
April 2015	2,019 calls	5,232 calls	38.6%
May 2015	2,691 calls	5,632 calls	47.8%
June 2015	2,587 calls	5,001 calls	51.7%

49.8%

of our calls are from people who have called two times or more in any given month.

Top 10 Alameda County Cities (N = 27,495)

Oakland	16,575 calls	**Emeryville**	809 calls
Berkeley	8,256 calls	**Alameda**	780 calls
Livermore	1,475 calls	**San Lorenzo**	630 calls
Hayward	1,392 calls	**Fremont**	305 calls
San Leandro	996 calls	**Castro Valley**	114 calls

This data is under-reported. Data is available on **27,495 calls** or **45.3%** total call volume. The data is duplicated. The city data is for each call.

Non-English Languages (N = 166)

Spanish	138 calls	**Bosnian**	1 calls
Cantonese	7 calls	**Burmese**	1 calls
Mandarin	5 calls	**Farsi**	1 calls
Vietnamese	4 calls	**Hindi**	1 calls
Arabic	3 calls	**Malaya**	1 calls
Korean	2 calls	**Portuguese**	1 calls
		Russian	1 calls

These counts may be under-reported.

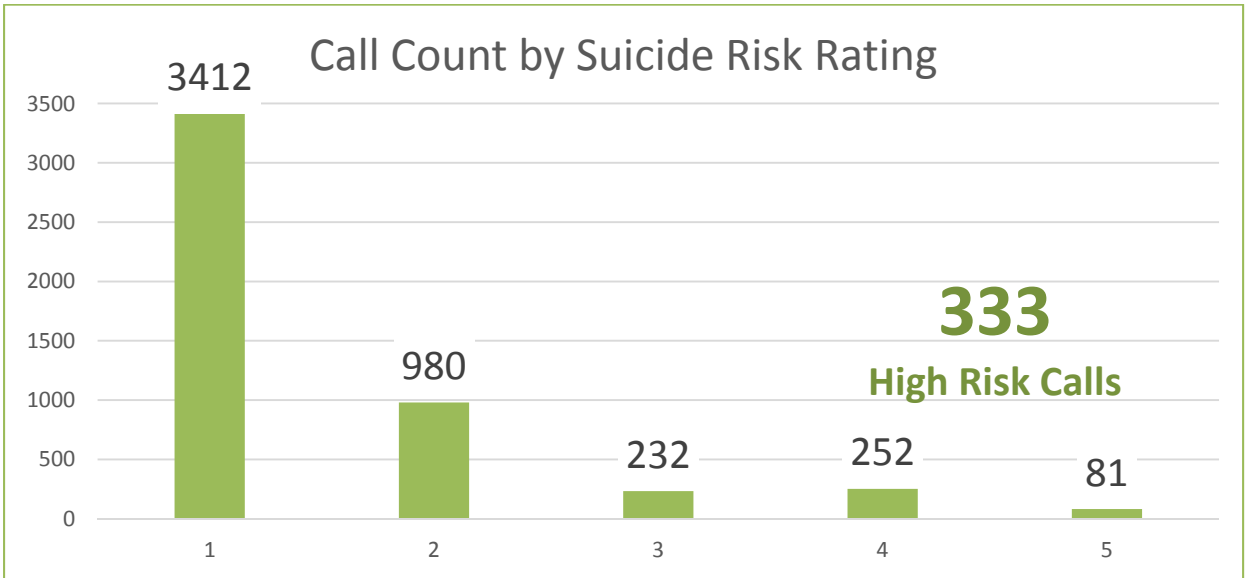
To connect with callers who do not speak English, we utilize a translation service that can translate in over 140 languages.

Suicide Related Calls

On the crisis lines, we measure suicidal content in crisis calls with three different methods. 1) Each call is rated on a suicidality scale of 0-5 by the crisis line counselor. 2) For callers with suicidal thoughts or feelings, counselors ask the caller to self-report on suicide intent at the start of the call, and at the end of the call. 3) Lastly, we have a thematic approach to capture data regarding suicide related calls.

Total Number of Calls with Suicide Rating 1 and above **4,957 calls**

Number of Unique Callers with Suicide Rating 1 and above	1,962 Unique Callers
Number of Returning Callers where one of their calls had a suicidality rating of 1 or above (They called at least 2 times this year)	750 Returning Callers
Number of Callers with Suicide Rating 1 and above who connected to the crisis line only one time	1,212 One Time Callers



EXPLANATION OF RATINGS

0 = No talk or thoughts of suicide
1 = Has suicidal thoughts or feelings; has no plan or means to enact plan
2 = Thinks of suicide, has devised a plan to die, does not have intent or means for suicide attempt
3 = Has persistent suicidal thoughts, has a plan & is actively trying to obtain the means to die
4 = Has a plan for suicide, easy access to the means, but has not yet taken any action to harm self
5 = Has recently made or is about to make a suicide attempt, wants to die, and is alone

Dispositions of Calls with Suicidality Rating at 4 or 5

A suicidality rating of 4 or 5 is considered high risk for a suicide attempt or suicide death. The caller had a specific plan, access to means, or had already harmed themselves. **A total of 333 calls** were rated with high suicide risk.

For many callers, talking with the crisis line counselors will de-escalate the stress level and urgency of the callers which means police and hospital intervention is not necessary. Our counselors are trained to work collaboratively with the caller to find alternate ways to manage their suicidal thoughts and feelings. Below is a table of high suicidality call dispositions.

Disposition	Count
Disable the means - This might include putting the pills or knife in another room, or it would mean moving away from a dangerous location like a train track.	65
Transported Self to Hospital – Sometimes, the caller was on the way to the hospital when they called, and they needed a little encouragement to walk in.	4
Family Member Transported Person at Risk to Hospital – Crisis counselors work to find the least invasive course of action to support the caller's safety. Having a friend or loved one transport the person to the hospital is ideal.	11
Self-Soothing Skill – This is an important component of safety planning. These may include going for a walk, playing video games, or doing art.	134
Personal Care – These are basic needs activities including eating, sleeping and bathing	117
Take Medication – Taking medication as prescribe can help reduce stressful or uncomfortable feelings or thought patterns.	11
Social Support – Friends, family members, church or other community can help reduce feelings of isolation. The caller agreed to reach out to the loved one or to have someone visit.	86
Professional Care – This includes seeking help from a clinician, therapist or medical personnel	68
Referral – Sometimes, the crisis line counselor gave the caller a referral to a community based organization	22
Accept Follow Up Call – Sometimes, the crisis line counselor would arrange for a follow up call usually within an hour and up to 24 hours from the end of the initial call. The follow up calls may occur repeatedly throughout the day until the suicidal urges have passed. Breaking up the day into short manageable chunks of time can help the caller get through the crisis.	61
Nothing – Some calls ended with no clear safety plan.	34
Abrupt Ending – Some calls ended abruptly and the counselor was unsuccessful in reconnecting with the caller.	9

Emergency Procedures by Call Line

ACCESS Afterhours	7 calls
Crisis Support Services of Alameda Crisis Lines 1-800-309-2131	89 calls
National Suicide Prevention Lifeline 1-800-273-TALK	52 calls
TOTAL	**148 calls**

If a person is at imminent risk for suicide or if a person has already harmed themselves with the intent to die, then crisis counselors will call for a wellness check from the local police department, with or without the person's permission. **148 out of 333 high risk calls** resulted in police intervention and hospitalization. This means that more than half of the high risk calls were deescalated over the phone without the use of external intervention.

Referrals made to callers with high suicidality rating

We are not able to effectively capture and report referral data for our entire call volume. We looked more closely at the 333 high suicide risk calls. Of those calls, referrals were made to the following community based organizations.

17th Street Detox Center	Child Protective Services	Mobile Crisis Unit
211	Crisis Response Team	One-Stop Career Center
A Safe Place	Family Education Resource Center	Sausal Creek
Alcoholics Anonymous	Financial Assistance	SF Peer Warm Line
ACCESS	Grief Counseling	Text Line
Adult Protective Services	John George Psychiatric Pavilion	Veterans Affairs
Bay Area Crisis Nursery	National Crisis Line	Washington Hospital
Bay Area Legal Aid	Narcotics Anonymous	Willow Rock
Cherry Hill	NAMI	Youth Hotline

Calls with Suicide Related Concerns (N = 6,478)

There were many other calls that were related to suicide, even if the caller themselves had no current risk of suicide.

A call is related to suicide if it fits one or more of these categories	
A Suicide Attempt in Progress	58
A caller has expressed Suicidal Intent	319
A caller has expressed Suicidal Desire	4,895
A call is regarding a loss due to suicide	52
A third party is calling in regards to someone they are concerned about	726
A caller is asking for information on suicide (i.e. warning signs)	109
A caller discusses past suicidal ideation or past suicide attempt	319

More than one concern may be have been present in a call. Distinguishing between Suicidal Intent and Suicidal Desire helps crisis counselors more accurately assess suicide risk. Suicidal Intent and Suicidal Desire are often confused. Suicidal Desire refers to suicide ideation (thoughts of suicide), intense psychological pain, feelings of hopelessness and helplessness, feeling trapped or intolerably alone. In contrast, Suicidal Intent refers to an expressed intent to die, a plan to kill self/other, an attempt in progress, and/or preparatory behaviors. Helping callers distinguish between the two can be very empowering for the caller. It can encourage callers to explore ways to feel better without acting on the suicidal thoughts and feelings.

Self-Reported Suicidal Intent Rating

Our counselors asked callers with suicide risk at the beginning and at the end of call to self-rate their suicide intent.

"On a scale of 1-5, how likely are you to act upon your suicidal thoughts and feelings at this time?

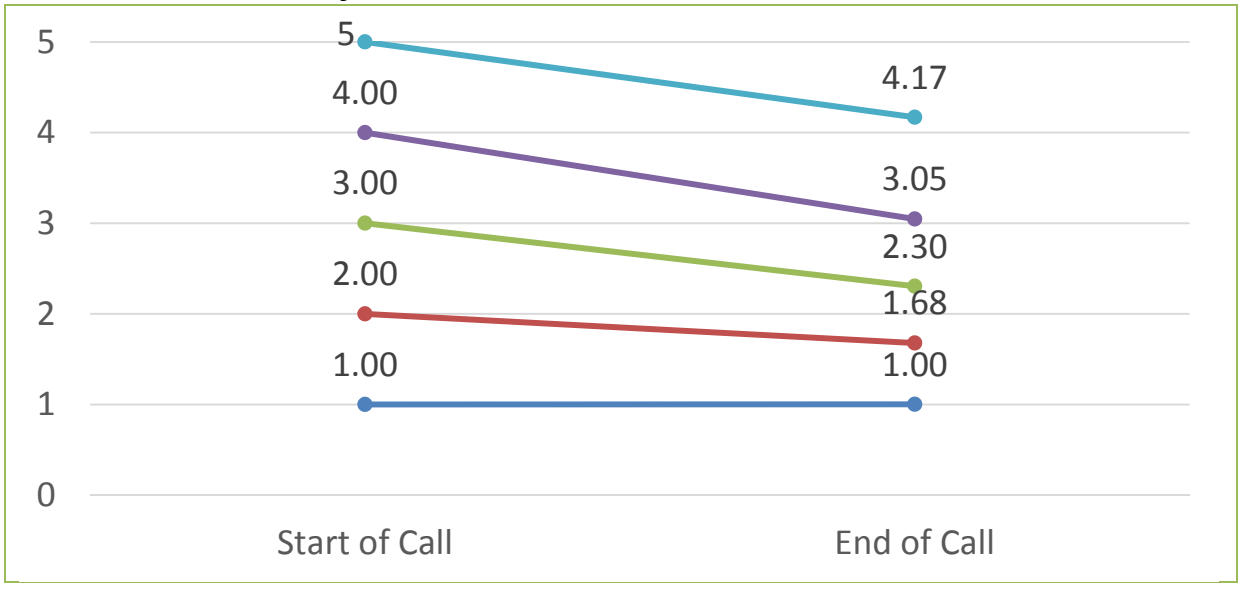
Where 1 represents "Not Likely" and 5 represents "Extremely Likely."

Suicidal intent is a good measure because it is most likely to change during the call. Asking the caller to self-rate, instead of using counselor's rating of caller's risk, decreases subjectivity. Self-rating can be helpful to the caller because it helps the caller distinguish between feelings and actions. It can also be therapeutic for the caller to understand that talking about their pain and feelings is different than acting upon them. And finally, the assessment can assist the counselor and caller to collaboratively decide on the level of intervention.

Suicidal Intent Ratings

Self-Rated Intent (N= 4,395)	N	Average Rating at End of Call
If caller rated 1 at Beginning of Call	2,911 calls	1.00
If caller rated 2 at Beginning of Call	920 calls	1.68
If caller rated 3 at Beginning of Call	384 calls	2.30
If caller rated 4 at Beginning of Call	109 calls	3.05
If caller rated 5 at Beginning of Call	71 calls	4.17

Suicidal Intent Trajectories



Follow-up can promote collaboration between counselor and caller and provides an opportunity to reassess the caller for safety. It is important to report on both the number of people contacted and the number of times a counselor tried to reach the caller. This reflects the effort and resources needed to contact callers.There are various times a crisis line counselor would reach out to a caller or follow up after a crisis line call. This table summarizes the most common scenarios.

Types of Follow Up

Follow Up after Emergency Procedures Within 3 days and up to 2 weeks after Emergency Procedures, the crisis line counselor will follow up with the caller. In this call, caller and counselor will have the opportunity to repair any rapport that may have been damaged, and we assess suicidal potential and continue to collaboratively build a safety plan.
Follow Up after an Abrupt Ending Call Sometimes, the call ends abruptly. If the caller had indicated high lethality or easy access to means, the counselor will try to reconnect with the caller.
Follow Up as part of a Safety Plan The crisis line counselor may offer to call the person back after a short interval to help the caller manage suicidal thoughts and feelings. These calls usually occur within an hour of the original call. In the time in between the first crisis call and the follow up call, the caller is encouraged to utilize a self-soothing strategy, or reach out to a support person.
Follow Up as part of a Third Party Call Sometimes, we receive calls from a third party, and from a preliminary assessment, we may deem the caller at higher risk for suicide. At this point, the crisis counselor may reach out and talk directly to the person at risk. The counselor can then provide a more thorough suicide assessment, and to work collaboratively to find the most appropriate intervention.
Follow Up to give Caller Additional Resources Sometimes the crisis line counselor must do additional research to find an appropriate referral for the caller and will call back with the referral.

Total Follow Up Efforts

Number of People Eligible for Follow Up	209 calls
Number of Calls with Successful Contacted	104 calls
Number of Follow Up Calls Initiated	226 calls

Unfortunately, I only have aggregate follow up data. I cannot break it down by follow up call types.

As an agency that values diversity, it is important for us to measure the makeup of our community. Diversity in our pool of crisis counselors fosters a richer experience for our callers. We asked each incoming trainee to fill out the demographic survey. We received 75 completed surveys out of 83 total trainees (90.4% Response Rate)

Contact with people who have different backgrounds than their own strengthens crisis counselors' ability to work with callers from diverse communities. Biases and judgments are explored in the training program. Crisis counselors often times share stories of their own lived experience. The sharing helps ameliorate the "othering" effect of our callers when crisis counselors reflect on their life experiences and realize that their own experiences are not too different than the experience of the callers.

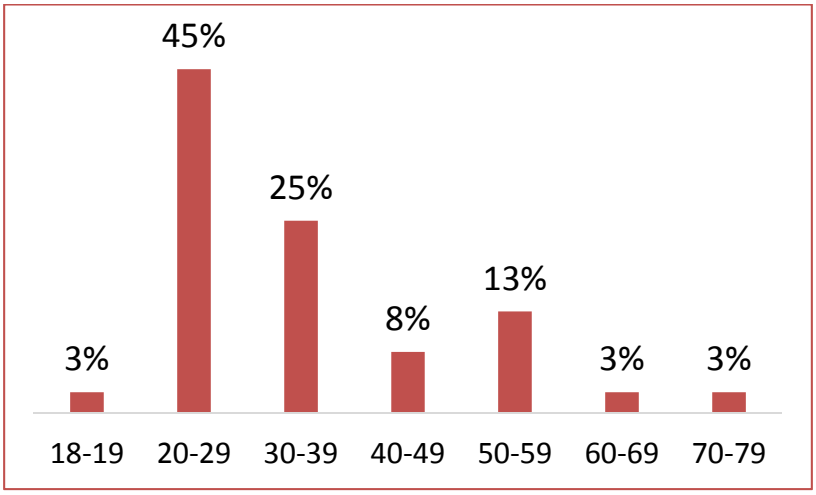
Disability, race, gender, age, and language capacity were also measured in the survey. The results are summarized on the following pages.

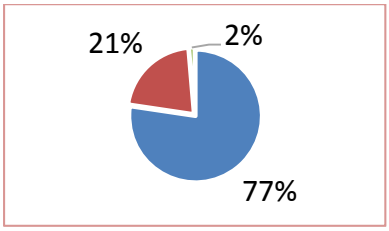
Lived Experience (75 Responses)

Question On the Survey	Yes	Percentage of Surveys
Do you or someone close to you live with one or more mental health concerns?	46	60.5%
Have you or someone you care about dealt with suicidal thoughts and feelings?	61	80.3%
Has someone close to you died by suicide?	22	30%
Are you currently a mental health professional, or currently pursuing a career in mental health?	29	38%

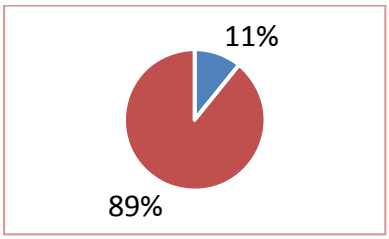
What race do you identify with most?		
Asian or Pacific Islander	12	16.00%
Bi-racial or Multi-racial	6	8.00%
Black	7	9.33%
Black, Bi-racial or Multi-racial	1	1.33%
Black, Native American	1	1.33%
Caucasian/White	36	48.00%
White, Asian or Pacific Islander	1	1.33%
White, Black, Native American	1	1.33%
White, Hispanic	1	1.33%
Hispanic	7	9.33%
Unknown	2	2.67%

Age Range	Count
18-19	2
20-29	34
30-39	19
40-49	6
50-59	10
60-69	2
70-79	2

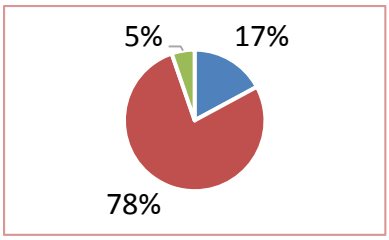




Gender		
Female	58	77.33%
Male	16	21.33%
Unspecified	1	1.33%



Self-identified as living with a disability		
Yes	8	10.66%
No	66	88%



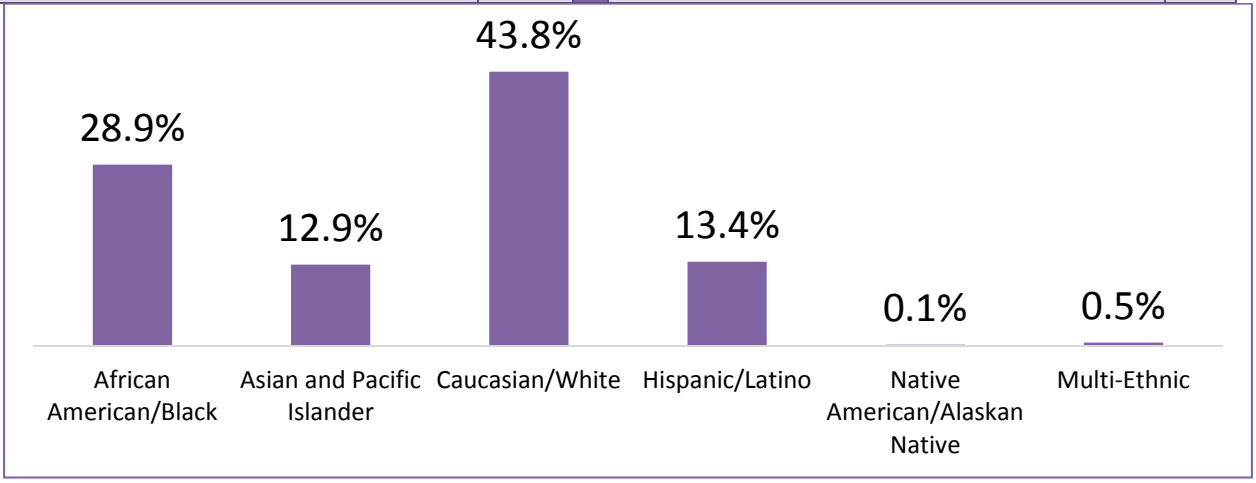
Self-identified as LGBTIQ		
Yes	13	17.11%
No	59	77.63%
Unknown	4	5.26%

Language	Count	Language	Count
Armenian	1	Japanese	1
Cambodian	1	Korean	2
Cantonese	3	Mandarin	2
Chinese (unspecified)	1	Spanish	11
French	3	Tagalog	1
		Vietnamese	1

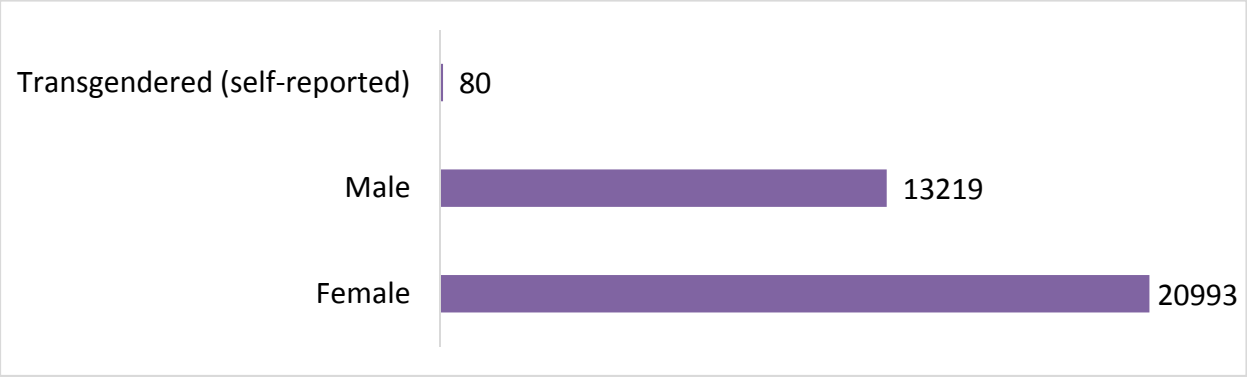
Demographic data continues to be a challenge. Due to the nature of the crisis lines, our crisis counselors prioritize crisis intervention and safety of the caller over taking demographic data. However, this data is important in informing our outreach and training objectives.

Race/Ethnicity (8,164 calls or 13.4% of total calls)

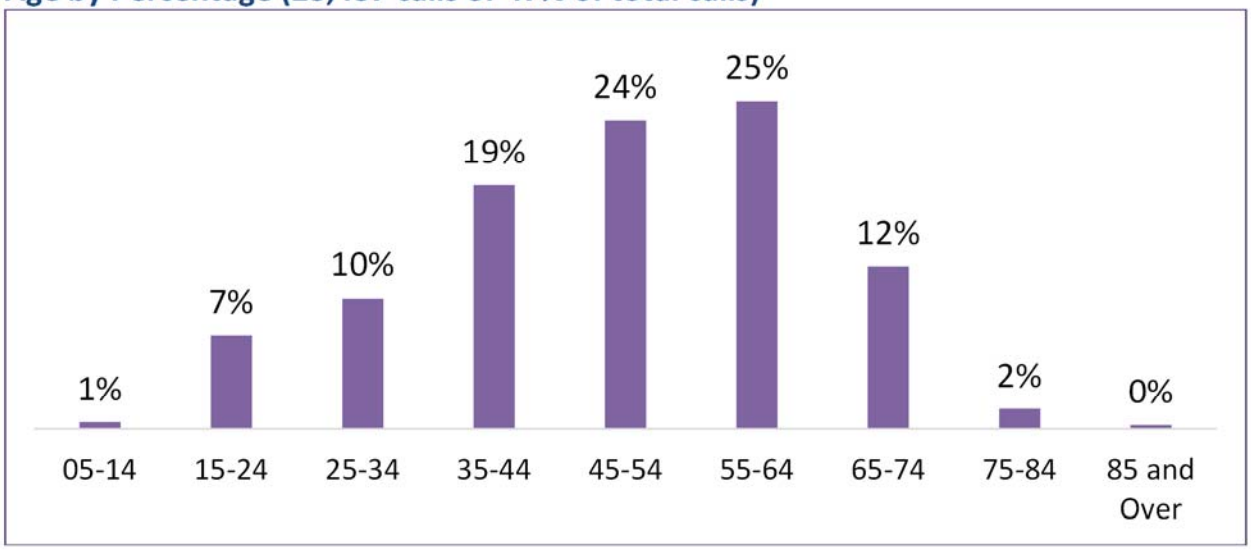
White/ Caucasian	3569	**Saint Lucian (Caribbean)**	2
Black/ African American	2361	**Afghan**	1
Latin American	1094	**Egyptian**	1
Asian	859	**European Immigrant**	1
Fillipino	193	**Fijian**	1
Multi-Ethnic: Puerto Rican/White	36	**Hungarian**	1
Arabic	14	**Multi-Ethnic: White and East Indian**	1
Native American/Alaska Native	12	**Multi-Ethnic: White, Native American, African American**	1
Middle Eastern Immigrant	7	**Nigerian**	1
Indian	3	**Somalian**	1
Multi-Ethnic: Black/Puerto Rican	2	**Spanish**	1
Greek	2		



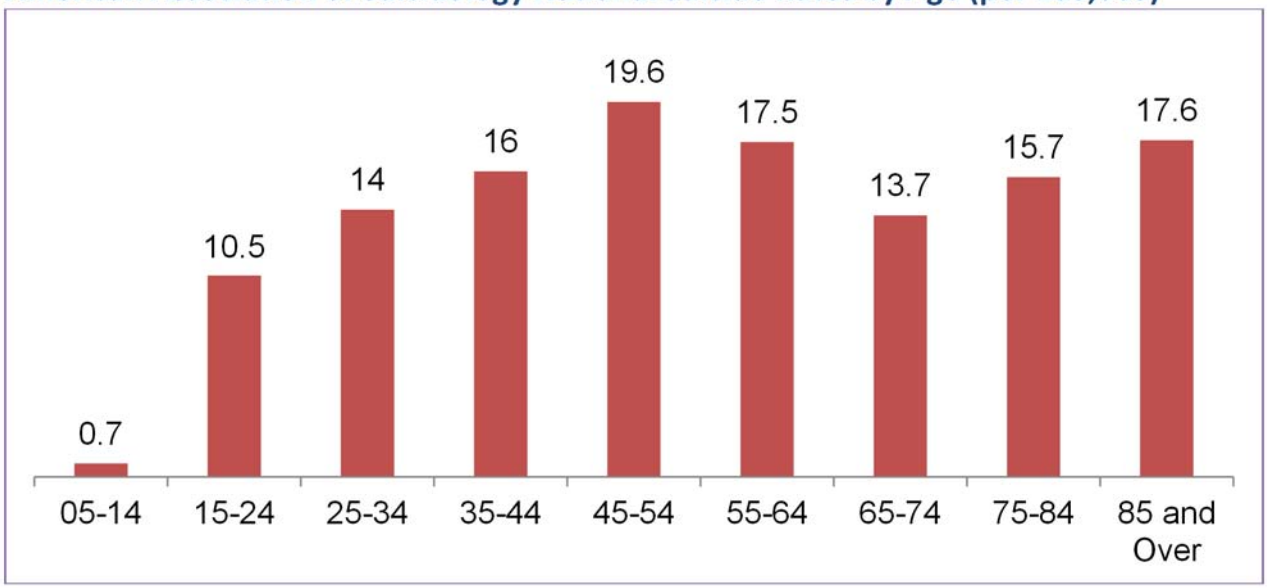
Gender (37,061 calls or 61% of total calls)



Age by Percentage (28,487 calls or 47% of total calls)



American Association of Suicidology National Suicide Rates by Age (per 100,000)



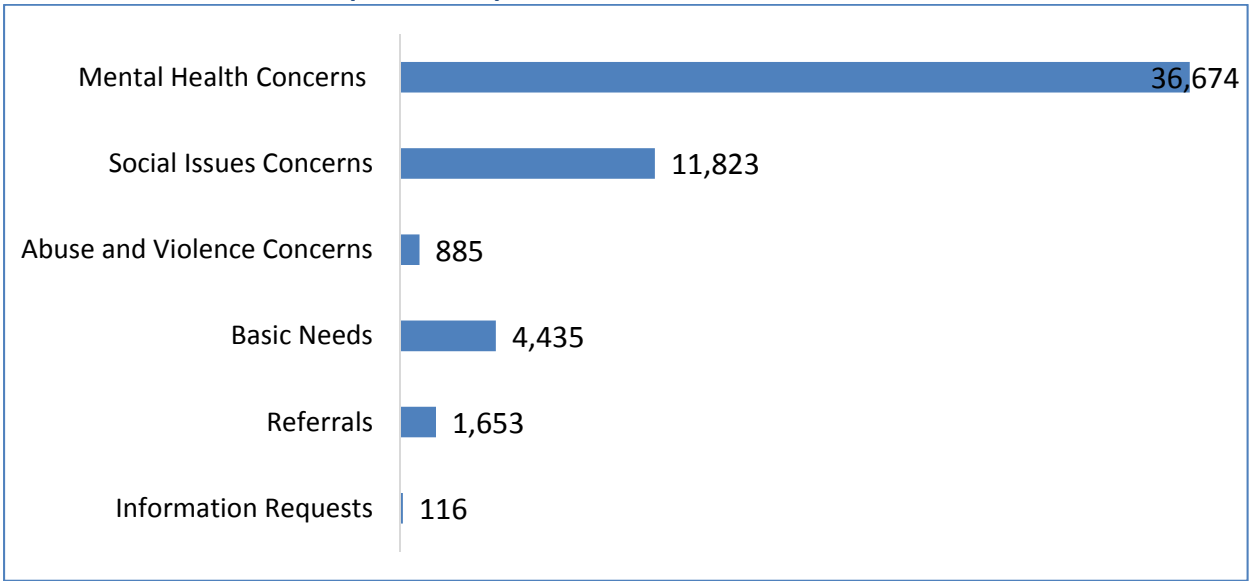
Age information is available for 47% of callers. Included is the distribution of suicide rates nationally. People age of 65+ have comparable death rates as those aged 55-64, yet on the crisis lines, we see low rates (14%) of callers age 65 and up. This indicates a need for further outreach to people 65 years of age and up.

2,144 calls

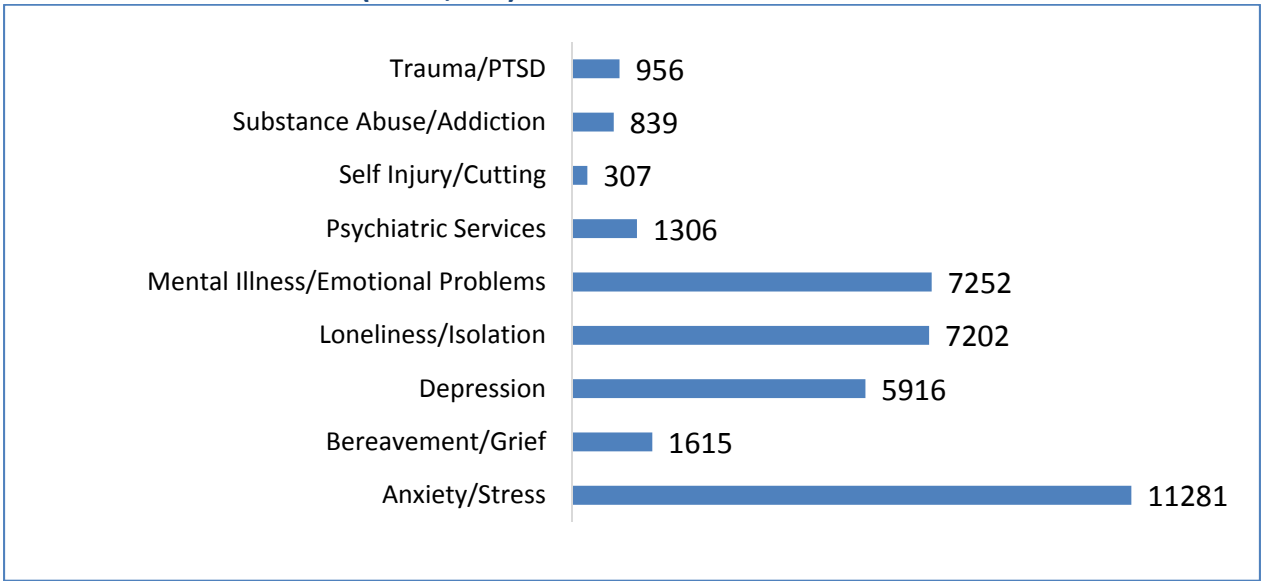
were from transitional age youth 16-25 years of age.

Mental health concerns were the most common reasons for calling the crisis lines. More than one concern may have been discussed in a single call. This data is representative of number of incidents, not number of calls. Not all callers self-report on all concerns of prevalence. These numbers are under-reported due to inconsistency in crisis counselors data input.

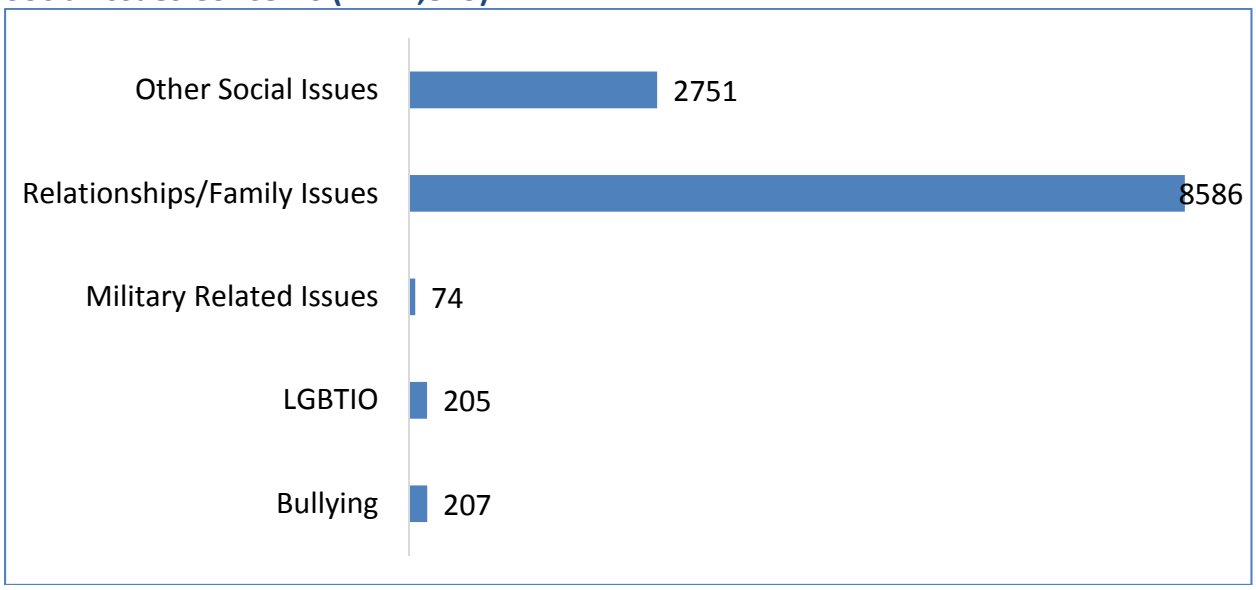
Overall Caller Concerns (N=55,586)



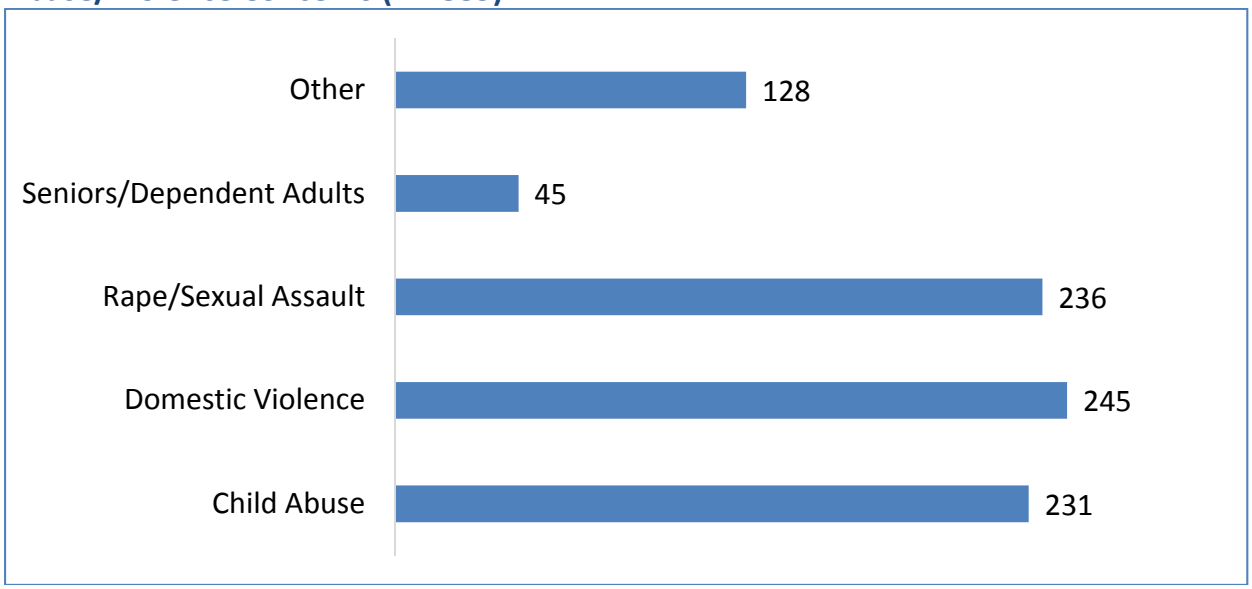
Mental Health Concerns (N=36,674)



Social Issues Concerns (N=11,823)



Abuse/Violence Concerns (N= 885)



Additional Caller Concerns

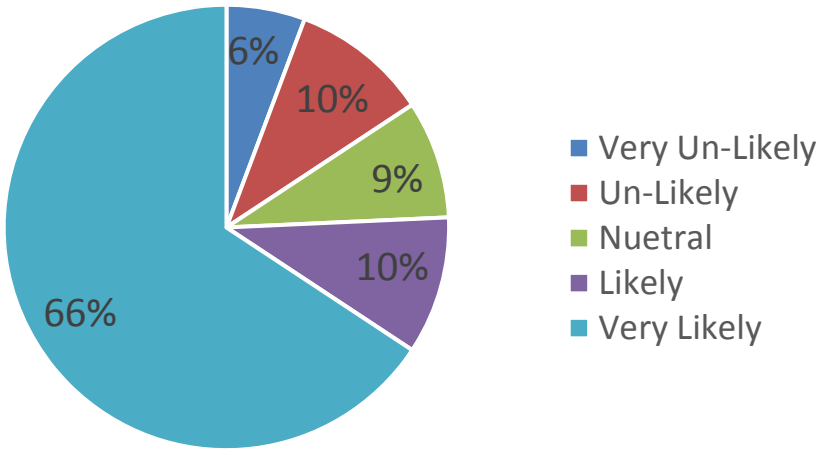
Basic Needs	4,435
Referral	1,653
Information/Materials Request	116

Caller Satisfaction Survey

Caller satisfaction surveys provide information on the effectiveness of a call and a caller's experience. We conducted our survey in October 2014 and callers were given an option to complete the survey. Callers were transferred to an interactive Voice Response System (IVR) to answer three questions with the option to leave a voice message. (Surveys with less than 3 questions answered were not included below). We received a total of 71 completed surveys.

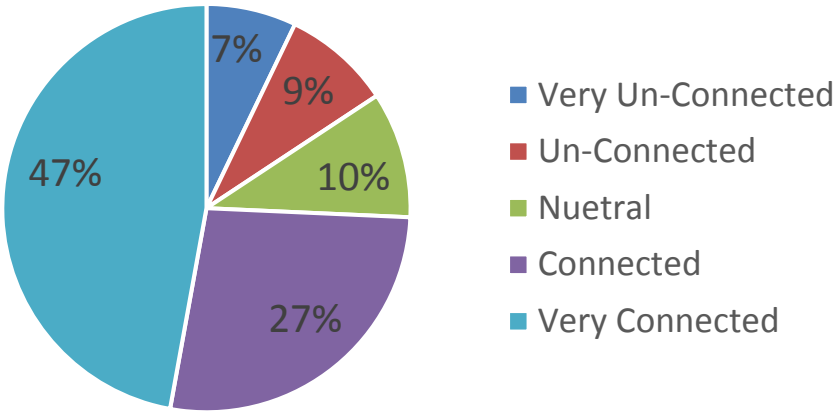
On a scale of 1 to 5, how likely are you to call again if you need help?

75.7% of callers said they'd be "Likely" or "Very Likely" to call the crisis line again.



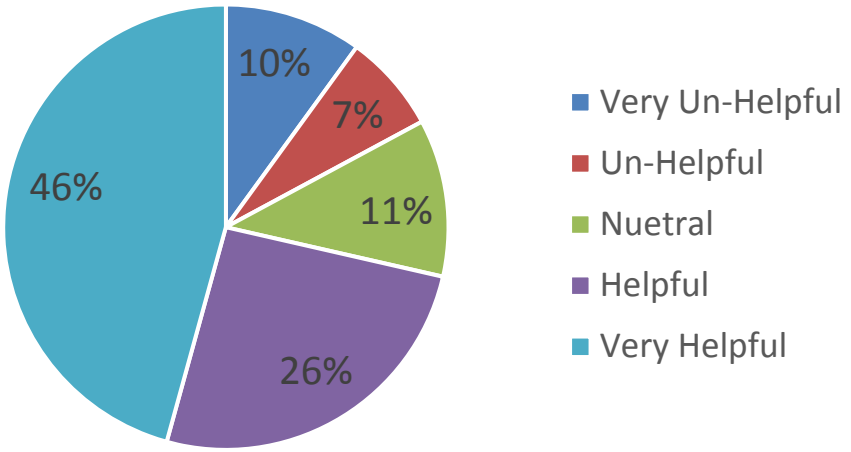
On a scale of 1 to 5, how connected did you feel to the counselor?

74.3% of callers said they felt "Connected" or "Very Connected" to their counselor.



On a scale of 1 to 5, how helpful was this call in reducing your emotional distress?

71.4% of callers said the call was "Helpful" or "Very Helpful" in reducing distress.



We received 12 voice messages in total from the survey. Here are a few examples.

Examples of Feedback
Hi there, I call the help line a lot and they are really helpful to me and very reassuring to know that someone is here, even just for like 5 minutes. I find it very helpful and very glad you guys are there. You guys are doing a great job. Ok, thank you!
Hey, the counselors, they are good but they always just recommend counseling. I still find them very helpful but maybe try to get them, not quick stick solutions but maybe some personal experience to how they got over their problems. Maybe this will help too.
I would just like to say, when someone listens to me, they are not judging me. It is very useful to me and I get so sad, it's not good to be judged when you are sad. I'm just trying to get through a difficult time and this has been very helpful.
I think this is a very good service and necessary. I was having an anxiety attack for like 4 hours and I finally called and was able to just, you know, talk to someone. I tried coping with it, you know did weird things, like put on socks and turn off the lights in my room. You know, talking to someone just help alleviate the stress. It really deflated the situation and I feel very good about things now. It was a complete turnaround. Thank you.

Follow Up Program

We can strengthen our follow up program by reaching out to more callers with presentation of higher suicidal potential. Some callers were assessed by our crisis line counselors to need emergency procedures, but when the police arrived, the police did not take the person to the hospital. A follow up call can be helpful for those callers in maintaining safety, and re-establishing trust if any rapport may have been damaged. For many people who receive referrals from crisis line counselors, a follow up call may be helpful in confirming and supporting a community member in connecting with a community resource. The Crisis Line Program also has the potential to expand the follow up program by receiving referrals from Alameda County Behavioral Health Care Services partners including John George Psychiatric Pavilion.

Suicide Prevention and Social Media

Many of our third party calls this year involved some form of social media. In response, our Text Line Coordinator, Karen Oberdorfer, created a document that summarized the various reporting protocols if a social media post contained suicidal content. Next year, we hope to report on the types and number of crisis line calls related to social media.

Strengthen Data Gathering

At this time, the demographic data we have about our callers is from a small sample. If we improve our sample size, we can get a better picture of who is calling the crisis lines. We plan on updating our database to streamline data collection process as well as providing on-going training. We would also like to better report on referrals made, and track linkage to community based organization and ACBHCS with our follow up calls.

Bibliography

1. "BART launches crisis intervention campaign" https://www.bart.gov/news/articles/2015/news20150414

2. Carter, G.L., Clover, K., Whyte, I. M., Dawson, A. H., & D'Este, C. (2013). Postcards from the Edge: 5-year outcomes of a randomised controlled trial for hospital-treated self-poisoning. British Journal of Psychiatry, 202(5):372-380.

3. Gould, M. S., Kalafat, J., Munfakh, J. L. H., & Kleinman, M. (2007). An evaluation of crisis hotline outcomes part 2: Suicidal callers. Suicide and Life-Threatening Behavior, 37(3), 338-352.

4. Kalafat, J., Gould, M. S., Munfakh, J. L. H., & Kleinman, M. (2007). An evaluation of crisis hotline outcomes part 1: Nonsuicidal crisis callers. Suicide and Life-Threatening Behavior, 37(3), 322-337.

5. Stanley, B. & Brown, G. K. (2008). The Safety Plan Treatment Manual to Reduce Suicide Risk: Veteran Version. Washington, D.C.: United States Department of Veterans Affairs. http://www.mentalhealth.va.gov/docs/va_safety_planning_manual.doc

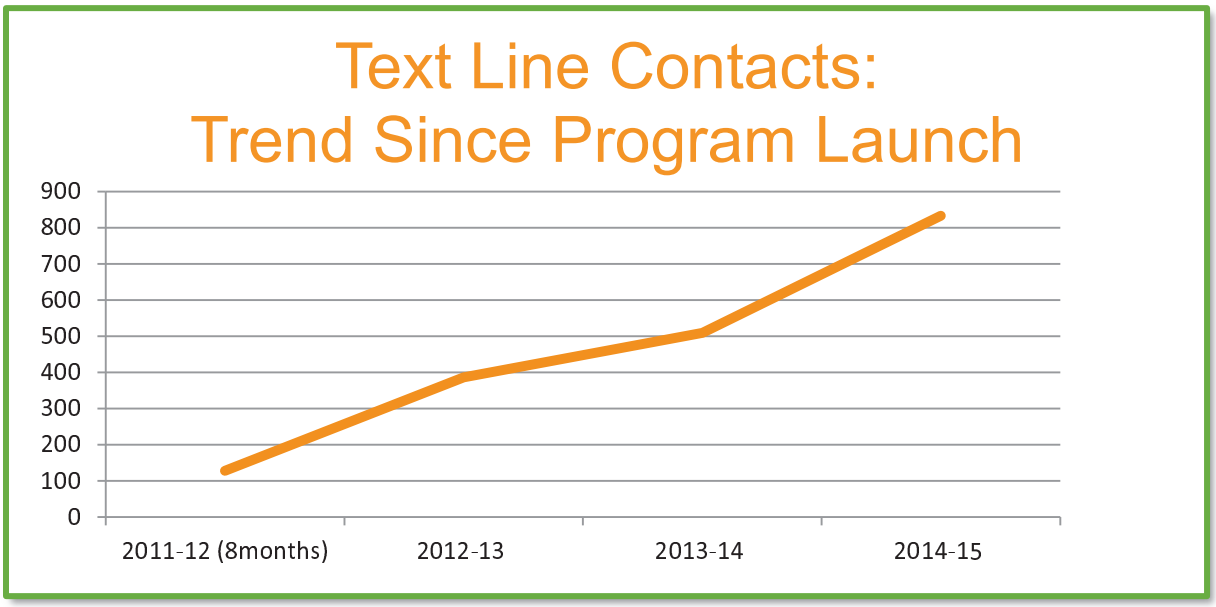
6. Suicide Risk Assessment Standards – National Suicide Prevention Lifeline http://www.suicidepreventionlifeline.org/media/5388/Suicide-Risk-Assessment-Standards.pdf

7. The Way Forward: Pathways to hope, recovery and wellness with insights from lived experience. Prepared by the Suicide Attempt Survivors Task Force of the National Action Alliance for Suicide Prevention. http://actionallianceforsuicideprevention.org/sites/actionallianceforsuicideprevention.org/files/The-Way-Forward-Final-2014-07-01.pdf

8. Training Manual for Crisis Center Common Metrics Implementation. California Suicide Prevention Network lead by Didi Hirsch.

9. US Census Bureau. http://quickfacts.census.gov/qfd/states/06/06001.html

CRISIS SUPPORT SERVICES
of Alameda County



Text Line Program
Year End Report
FY2014-2015

"I'm really glad this number is around, and thank you so much – Texter

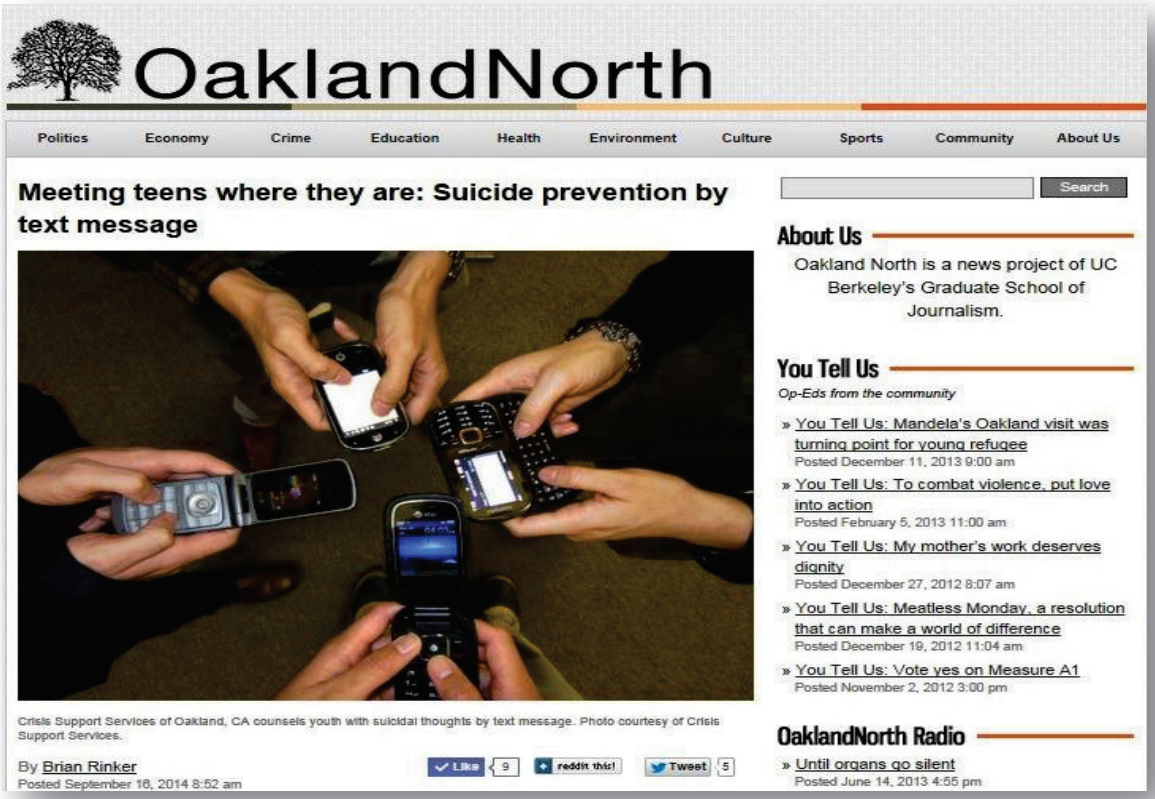
"Thanks so much for the help. I appreciate it a lot & I feel a lot better – Texter

Table of Contents

Introduction

This report includes statistics for Crisis Support Services of Alameda County's Text Line Program (Text Line), a discussion of issues that county youth are dealing with when they text us, and highlights of the year.

Fiscal Year 2014 -2015 was another high growth year for the Text Line. Most of the texters hear about the Text Line through presentations by our flagship Teens for Life (TFL) program. The groundwork established though the TFL program has helped spread the word to other venues. It will only be a matter of time before we will see more contacts from word of mouth, social media, and from local programs serving youth. For instance, the Text Line was featured in UC Berkeley's Graduate School of Journalism's paper in conjunction with National Suicide Prevention Week.



OaklandNorth

Politics Economy Crime Education Health Environment Culture Sports Community About Us

Meeting teens where they are: Suicide prevention by text message

Search

About Us

Oakland North is a news project of UC Berkeley's Graduate School of Journalism.

You Tell Us

Op-Eds from the community

» You Tell Us: Mandela's Oakland visit was turning point for young refugee
Posted December 11, 2013 9:00 am

» You Tell Us: To combat violence, put love into action
Posted February 5, 2013 11:00 am

» You Tell Us: My mother's work deserves dignity
Posted December 27, 2012 8:07 am

» You Tell Us: Meatless Monday, a resolution that can make a world of difference
Posted December 19, 2012 11:04 am

» You Tell Us: Vote yes on Measure A1
Posted November 2, 2012 3:00 pm

Crisis Support Services of Oakland, CA counsels youth with suicidal thoughts by text message. Photo courtesy of Crisis Support Services.

By Brian Rinker
Posted September 16, 2014 8:52 am

Like 9 reddit this! Tweet 5

OaklandNorth Radio

» Until organs go silent
Posted June 14, 2013 4:55 pm

This fiscal year we were able to continue to train active listening skills and assessment via text. We also continued to focus on particular areas that impact youth, such as non-suicidal self-injury, bullying and cyberbullying, and how to work with third party texters who are reporting disturbing material on social media.

Crisis Line volunteers and staff enjoyed learning how to work with crisis texters and found that the experience gave them a sense of connection with a hard to reach population, as well as improved their skills in general. Please see Appendix III for quotes of text counselors.

Special Acknowledgements

None of this year's accomplishments would have been possible without the hard work and "heart" investment of our CSS Crisis Line Counselors. Their text sessions continue to show empathy, solid assessment skills, and an ability to use crisis counseling skills in whatever format serves our client base.

In addition, a few counselors contributed their time to help develop this report. A special thank you goes to Maya Earle, MFT, Crisis Line Counselor, who spent countless hours analyzing text sessions for a qualitative review of texters' sessions.

We would also like to thank Crisis Line counselors Kimi Olsen, Quang Tran, Daniella Bermudez, Jasmine Ramezanzadeh, Elizabeth Weiss and Stephanie Yu, who helped develop the coding tools for the session analysis and gave valuable feedback.

Text Line Basics

- **When:** The Text Line operates 7 days a week, from 4:00 p.m. to 11:00 p.m.
- **How:** Alameda County middle and high school students "**opt-in**" to the service by texting the **keyword "Safe" to 20121.**
- **Free:** Most major cell companies, including Verizon and Sprint, do not charge texters when they reach out to hotlines on 20121.
- **Off Hours:** If a texter opts-in when the Text Line is closed, the texter will receive an auto message with the Text Line hours and the 24 hour National Suicide Prevention Lifeline's phone number.
- **Educational Message Services (EMS)** continues to be our vendor for the Text Line software.
- **Phone to computer:** Teens text us from phones, and we engage in sessions with them from CSS computers. The software prevents anyone from texting to the Text Line through a computer – it must be from a cell phone.

NOTE TO READERS: Any reference to texters in this report will have been anonymized for confidentiality. Often the gender will be a plural "they" and other identifiers will have been changed. The spirit of the exchanges will have been preserved.

Text Line contacts grew exponentially this year. Most texters find out about the Text line through Teens for Life (TFL). They gave presentations to 293 classrooms in Alameda County middle and high schools in FY 2014-2015. Presenters also distributed 10,000 cards with contact information for the CSS 24 Hour Crisis Line, the National Suicide Prevention Lifeline, and the Text Line. In addition, TFL distributed posters featuring those same resources.

Students texted about the TFL presenters making an impact on their mental health practices:

"I'm okay. Today at school we had the teens for life people come in and talk to us. And I just decided that I finally needed to talk to someone"

Other times texters spoke of how the TFL presenters normalized sharing difficult feelings with friends and the benefits of reaching out to the Text Line for support:

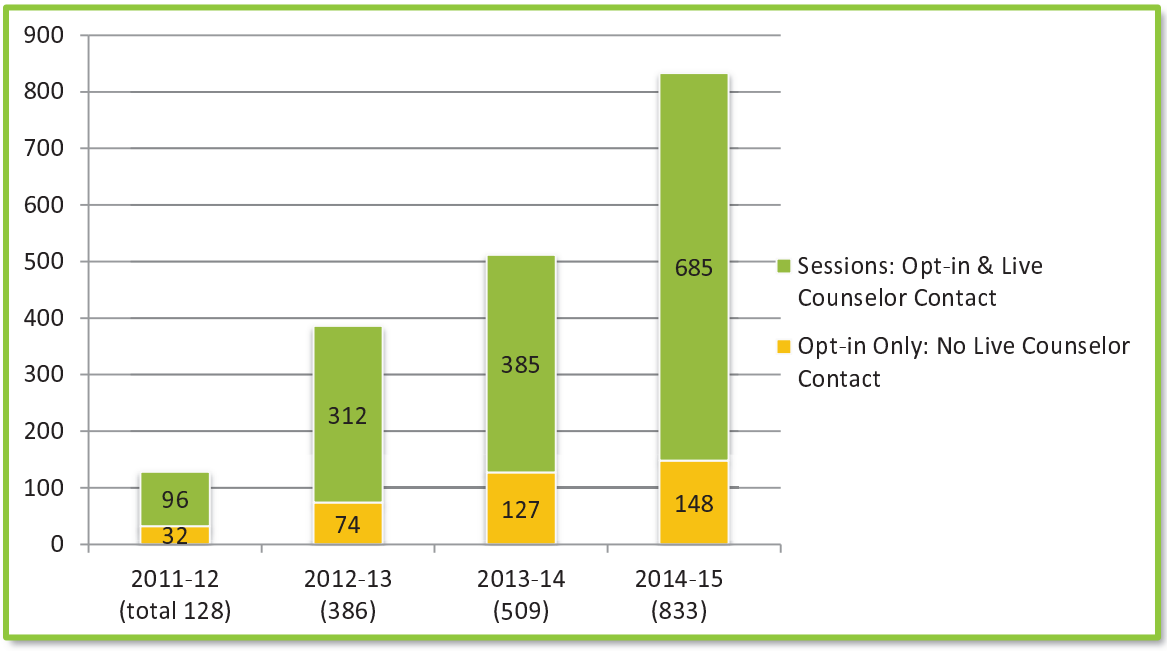
"My friend asked me what went down between us but I dont wanna tell her, she then told me 'im ur friend I can help you, remember what Mercedes told us during Science' while I was thinking about it I told her"

It can sometimes be a challenge for youth to feel entitled enough to ask for support. Presenters helped even the most timid youth feel empowered to try it out:

"Well today we had a guest speaker come in and tell us about how you can help teens or people and lately I've been sad and stressed I didn't know if I should or should not talk to u so here I am"

Youth responded to the presentations by texting CSS more than ever before. See chart on the next page comparing the numbers of youth contacts from the launch of the Text Line, in 2011, through the end of this fiscal year.

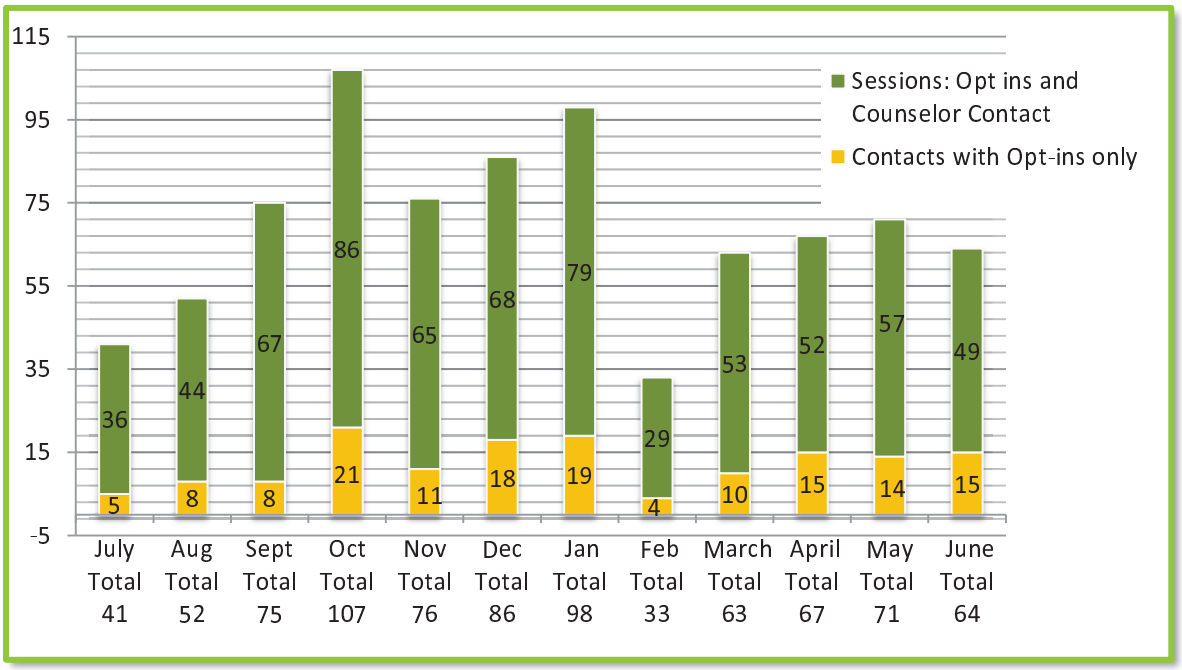
Text Sessions and Contacts by Year since Launch



"Contacts with opt-in only", means no interaction with a counselor occurred when the texter opted in. The most common reason (74% of the time) is when texters opt in when the Text Line is closed.

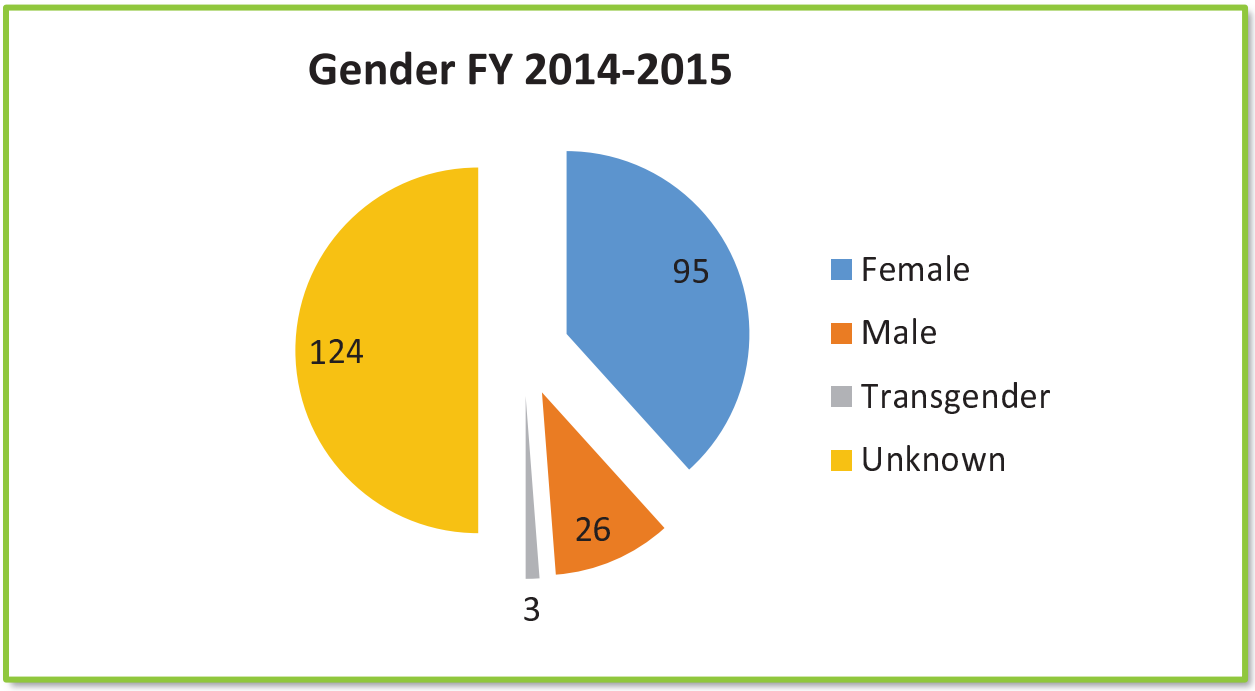
Text Sessions and Contacts by Month FY 2014-2015

The highest month, October, also was the month with the most TFL classroom presentations.



FY 2014-2015: Non Duplicated Texter Data

Total Unique Texters	249
New Texters in FY2014-2015	216
Returning Texters (2 or more opt-ins within this year)	94



9 Text Sessions
resulted in a report to
Child Protective Services

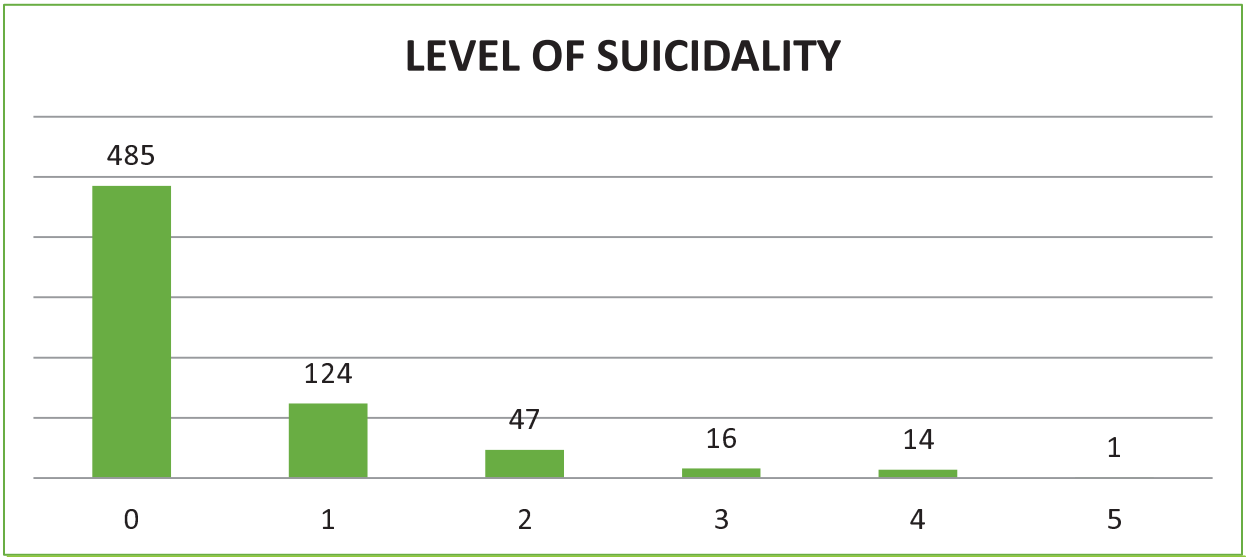
Suicide is the second leading cause of death among persons aged 10–24 years in the United States (Sullivan, Annest, Simon, Luo, & Dahlberg, 2015). As a suicide prevention resource, the Text Line meets youth where they are at– with their smart phone (Lenhart, A., 2015). Sometimes youth text us with thoughts they do not often share with others. We might be their first step towards connecting to more help:

“I guess I’m always seen as the strong one so not many people see I struggle too.

Suicide Risk Assessment

Because we are not able to hear the voice, counselors will assess even if the session content seems to be of low disturbance. A counselor might write, “I know this may be changing the subject for a moment, but I want to check in. Are you having any thoughts of suicide tonight?” If a texter is displaying high disturbance, a counselor might assess by sending. “I know this is really hard what you’re dealing with. I’m glad you’re texting about it. Are you having any thoughts of suicide?”

The measures below indicate ratings of suicidality as determined by counselors during text sessions.

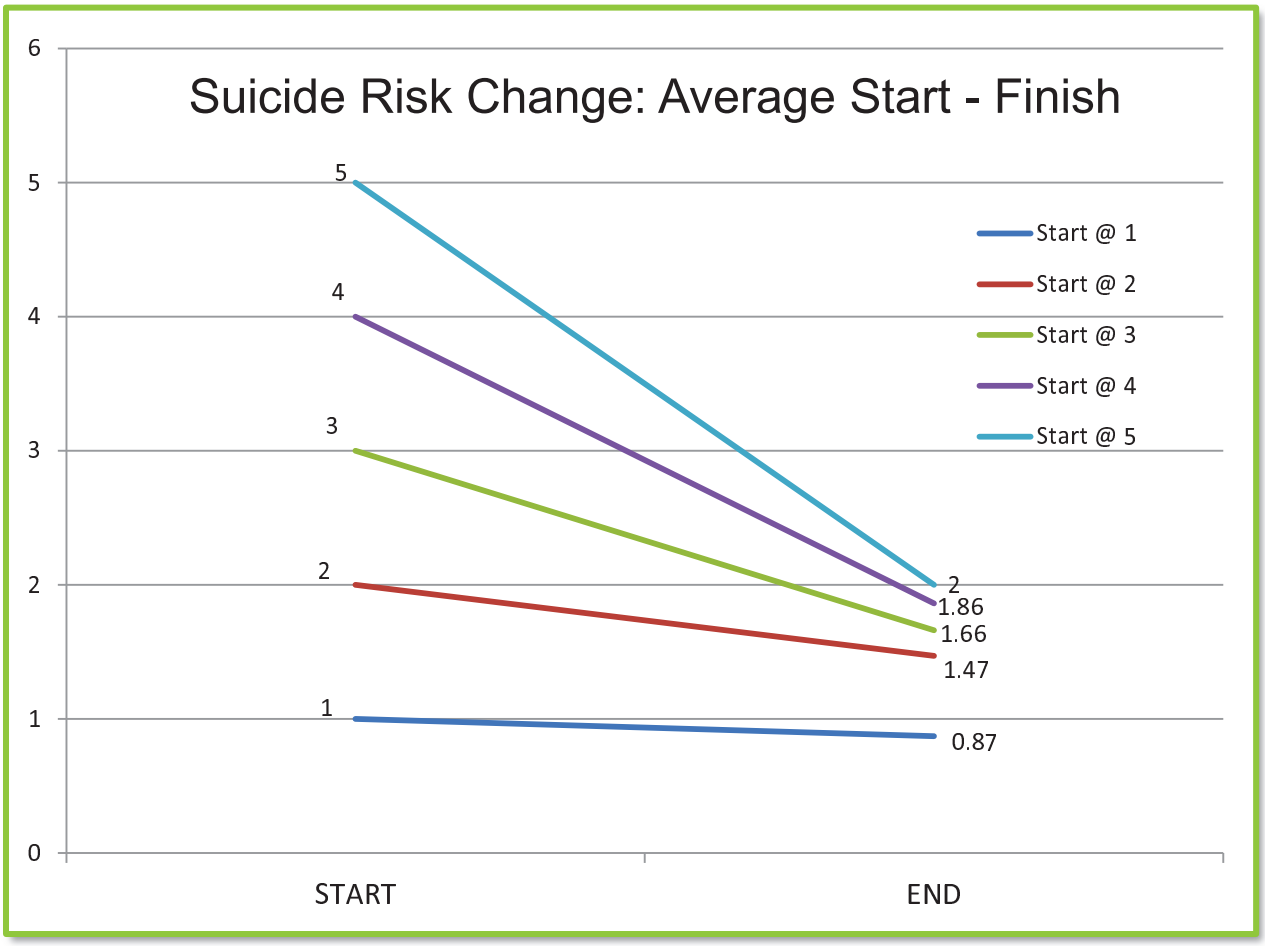


EXPLANATION OF RATINGS

0 = No talk or thoughts of suicide
1 = Has suicidal thoughts or feelings; has no plan or means to enact plan
2 = Thinks of suicide, has devised a plan to die, does not have intent or means for suicide attempt
3 = Has persistent suicidal thoughts, has a plan & is actively trying to obtain the means to die
4 = Has a plan for suicide, easy access to the means, but has not yet taken any action to harm self
5 = Has recently made or is about to make a suicide attempt, wants to die, and is alone

Counselor Rated Suicide Risk Change - From Start to Finish

In the chart below we can see counselor ratings for suicidality at the beginning and end of sessions.



High Suicide Risk Text Sessions

While many sessions this year involved no suicidal ideation or low level suicidality (0 – 1), we were contacted by some high risk texters, and as a result made outreach texts, consulted with CPS, police departments and mobile crisis units. During FY 2014-2015 we had no emergency procedures.

High Risk Text Session Example A

A texter wrote that they had a plan to kill themselves that night, they were alone, and had already made a superficial cut, but with the intent to die. This constituted a high rating, and in most cases we would have enacted emergency procedures but we did not in this case. At the end of the session safety had been established; they expressed that they were feeling much better, their parents had arrived home, and they would accept an outreach voice phone call the next day. During the outreach call the next day the

texter said they were doing much better. They were encouraged to continue to text as needed.

High Suicide Risk Session Example B

On another occasion a texter started the session saying they wanted to die. At various times they wrote that they felt no point to living, and at other times they wrote that the counselor was helping them feel better. The highs and lows cycled quickly, which concerned the counselor. The texter would not engage in safety planning, and did not agree to put distance between themselves and lethal means. Then they stopped responding. Their last message expressed hopelessness. However, 15 minutes later, while the counselor was on the phone with a mobile crisis unit preparing for emergency procedures, the texter started responding again and was adamant that they would be fine. They wrote that they had been on the phone with friends and did not see the counselor's texts saying she was going to send someone to check on them. Unfortunately, the rapport was ruptured at that point, but the texter now knows that if they feel imminently suicidal we can be a place to help keep them safe. This texter spoke of ongoing mental health challenges with depression and suicidal ideation.

High Suicide Risk Session Example C

There are times when texters start by dipping their toes in, such as with this texter, who wrote in one of their first sessions: "*I was actually curious as to how you get into volunteering over there?*" In a subsequent session they revealed they were experiencing suicidal ideation and had a plan. "*i cant stop thinking of dying and i feel like i eventually will take my life even by aspirin even if that takes a while and will be really painful*." In a phone call initiated by the texter it was determined that they would be safe that night, were not alone and their caregivers had arranged for counseling appointments. A week later the Text Line Coordinator sent the person an outreach text, letting the texter know we were checking in, and they can text us as needed.

High Suicide Risk Session & Safety Planning Example D

A texter had a number of sessions indicating suicidal ideation, high distress, with isolation, depression and the use of non-suicidal self-injury. In their first few text sessions, rapport was established and counselors focused on helping the texter access resources in the community (Willow Rock, and their school counseling department). During those early sessions counselors encouraged the texter to communicate with their parent, and developed plans for regulating their emotions once the text sessions were over. In a later, less acute, session where short term goals for self-regulating in the moment did not take precedence, a counselor asked if the texter might be open to creating a general safety plan:

COUNSELOR: Sam, I want to switch the subject for a sec if that's ok? I'm wondering if you'd like to make a plan with me that you could use to come back to for when you're feeling overwhelmed?
TEXTER: Sure that would be fun

COUNSELOR: You have a great spirit :)

TEXTER: Thank you :)

COUNSELOR: Sometime a good way to come up with a plan is first to identify when you are beginning to feel overwhelmed. Are you able to tell when you're starting to feel that way?

During the course of the session the texter expressed that the feeling of depression was constant which made them see any kind of stimuli in a negative light. They wrote down several activities, including ones mentioned in prior sessions, they could do in addition to texting the program.

Over the course of 7 months, the texter had evolved from experiencing suicidal ideation and feeling no one was aware of their pain, to communicating to their parent about the severity of their moods, and then to accessing therapy services.

MY3APP: Counselors are becoming adept at weaving in resources without breaking rapport. One newer resource is the safety plan app MY3App. Example with a suicidal texter, who texted in after a TFL presentation:

COUNSELOR: Have you heard of the MY3app before?
TEXTER: Yeah the guy talked about that today. Should I download it?

Lower Suicide Risk Text Sessions

In 2013 about 30% of youth nationwide felt sad or helpless for periods exceeding two weeks, which affected their normal daily activities. In the same year, 17% seriously considered attempting suicide (Frieden, T., Steve Kinchen, S., Shanklin, S., et al., 2014). Most of last year's sessions presented at this level: with depression and anxiety affecting normal daily activities, suicidal ideation but no plans to attempt soon.

A texter at this level who benefits from having access to a confidential text line wrote: "*I want to kill myself but I know that I can't and I hate it and I feel so stuck*" Another texter wrote after a counselor asked if they ever had thoughts of suicide: "*yes, and i do often yes, but i dont act on it*"

Lower Suicide Risk Text Sessions Example A

At the start of a session they wrote: "I'm suicidal. I hate living. It's torture being alive. Everyone tells me to just hang in there when all I want to do is be in peace". Counselor rated the suicide risk level at 2. Later, in response to continued counselor assessment, they wrote: "I have plans all the time. But I'm too much of a coward to do it." During the session rapport was established, the texter expressed what was distressing that day, and reported that they have a therapist. They stopped texting when the counselor attempted to create a post text plan. But just before the session ended they wrote: "I'm ok now. Just don't want stop talking to you. You've been really nice to me"

Lower Risk Texter Example B

TEXTER: "Hello, I'm just feeling very down today (this has been happening a lot within the past few months), and now suicide is a thought in my head"

COUNSELOR: "I'm so glad you reached out. We're here for you."

TEXTER: "I don't wanna die, but it seems like life just gets worse and nothing good ever happens anymore"

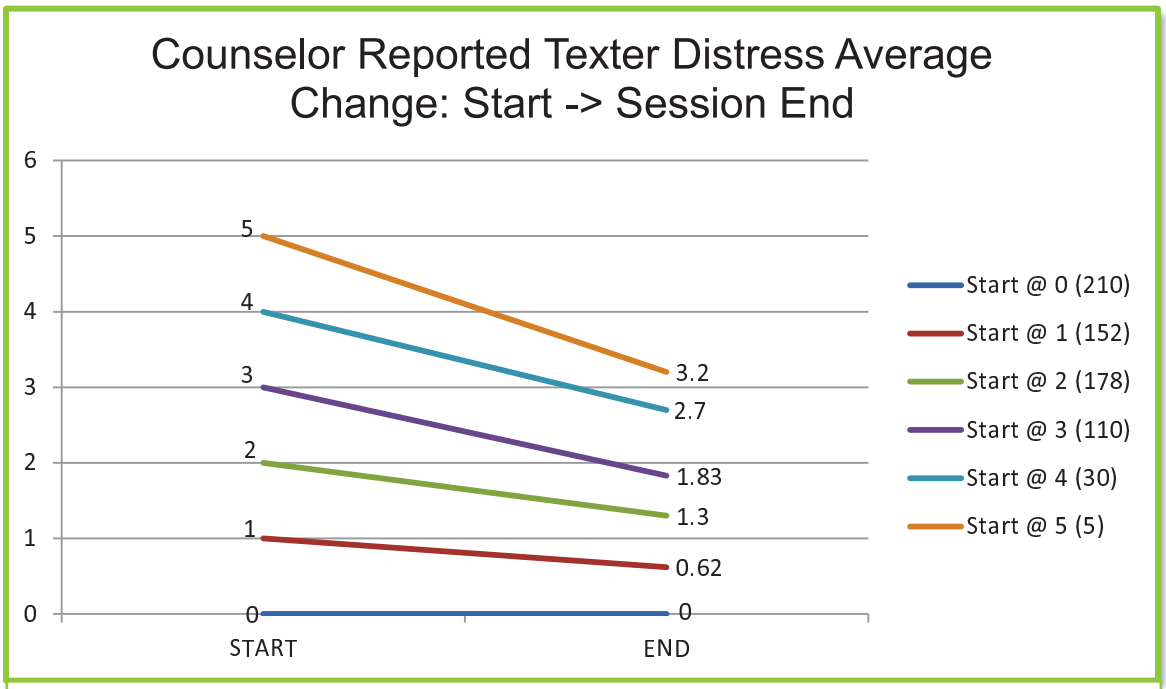
COUNSELOR: "It sounds like you don't want to die, but u want some relief & want things to get better, do i have that right?"

TEXTER: "Exactly!!! Yeah, everything just hit all at once within the past month"
During the ensuing session the counselor assessed again for suicide. The counselor used active listening to help the texter express what was disturbing them in the last few months. Safety was established, and the counselor encouraged self-care activities, including to text our service again. At the end of the session they wrote:

COUNSELOR:" it sounds so lonely for you right now. i want you to know that we are always here for you, Joanne."

TEXTER: "Thank you, that means a lot"

Counselors also tracked distress levels and the change of distress level from the beginning of the session to the end. It is a subjective measure of the counselors'. Most counselors underreported reduction of distress at the end of text sessions.



EXPLANATION OF RATINGS

0 = No Apparent Distress

1 = Minimal Distress

2 = Mild Distress

3 = Moderate Distress

4 = Significant Distress

5 = Very High Distress Level

Distress Level Change – Example A No Change

Often counselors underreport positive effects of the sessions. For instance, counselors often report no positive change or minimal positive change with one of our regular texters. One counselor reported the distress level at start to finish as a 1 to 1. Yet during the session the texter wrote: "*I just have to get used to it... I don't always like change and it sucks putting your all into something and not getting the same results back*". While the texter did not say they felt better, nor did they thank the counselor, the amount of trust, alliance, and counselor mirroring of intense thoughts during the session was probably helpful.

Distress Level Change Overt Positive Responses Example B:

TEXTER: “Thank you i think ima go i really appreciate yur help Miguel :)”

TEXTER: “It is true. I'm going to be safe tonight. Thank you so much for your help”

TEXTER: “My piano lesson is starting soon. Thank you for reassuring me this is a reliable resource and I'll still ask if my friend would see a counselor!”

TEXTER: “thank you so much for this talk”

TEXTER: “Thank you. This really helps. I also have issues with people at school. Not really issues like drama, but just people's opinions about me”

TEXTER: “Thanks for everything it really helped :)”

TEXTER: “you've been a big part of my life for the couple hours I've known you”

TEXTER: “I'm still a bit nervous but it's like a normal nervous that helped a lot thank you”

Example of a plan for dealing with substance abuse and indication of utility:

COUNSELOR: “One thing, if you ever start to relapse or any other time, like during a relapse, you can always text us for support. We don't judge anyone here”

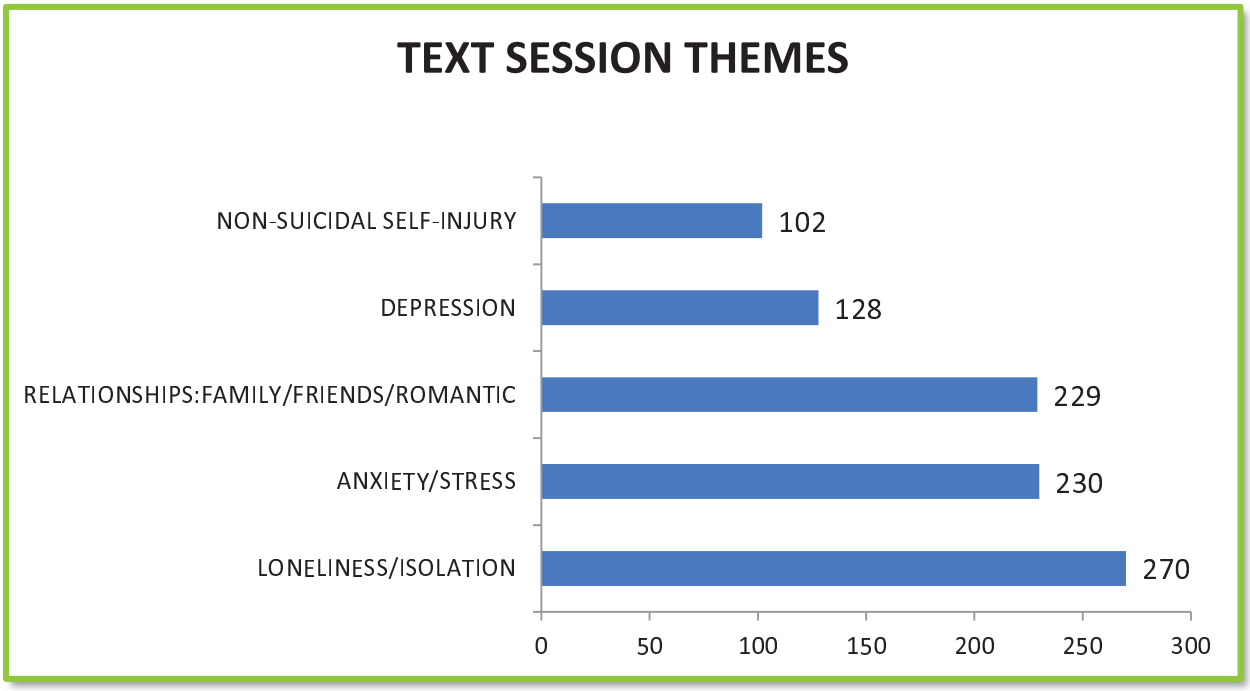
TEXTER: “I was just thinking that, thank you :) It will be nice to have somebody to chat with, during the darkest of days. And you've been a really big help and I wanted to thank you for being so supportive and kind”

Reasons for Texting

Many of our texts had multiple reasons for texting. We created "themes" for recurring reasons. They were coded for these themes if texters mentioned them within the text. Coded themes were determined via:

1. Coding of counselor write ups in our data base
2. Reading and coding the actual scripts

Below is a chart showing content themes with the largest number of text sessions. For more detailed theme examples, please see appendix I.



Returning Texters

Creating a safe place for adolescent texters to return to is important. Adolescence is a time of great change and intense excitement, as well as stress (Siegel, D. 2013). While the Text Line is an appropriate resource during an acute crisis, it also addresses the needs of texters along the whole crisis continuum. Our aim is to intervene before higher level of care interventions are needed, such as emergency procedures.

Texters who text more than once, "returning texters", might not always be in an acute crisis situation. The list below outlines issues that can grow into suicidal crisis' (CDC Violence Prevention, CDC Factsheet) or lifelong difficulty if no help is received.
Some reasons returning texters reach out to us more than once:

- During a temporary challenge but ongoing over several months
- Lifelong challenges such as difficult family dynamics
- Loneliness and Isolation, bullying
- During stable times but past crisis creates need for connection with safety net
- Problems related to emerging sexual and gender identification and LGBTIQ issues
- Difficulty with changing relationships as teens begin to "launch" from caregivers
- Onset of issues that can occur during adolescence:
    - Mental health disorders – Psychosis, Major Depressive Disorder
    - Non-suicidal self-injury
    - Eating Disorders

The association between suicidal ideation and depression in all ages is strong. Depression and related symptoms impact some returning texters. The average age of the first experience of a major depressive disorder during adolescence is 15 years and the experience can be episodic 75% of the time for the first 5 years. In one year up to 7% of adolescents have a major depressive disorder episode (Gladstone, Beardslee, & O'Connor, 2011). While we did not code for depression in sessions unless specifically referenced by the texter, many youth texted about symptoms and risk factors for subclinical depression and major depressive disorder (MDD). Some of the risk factors for MDD are a family member or caregiver with it, low self-esteem, low social supports and lack of positive coping behaviors (Gladstone, Beardslee, & O'Connor, 2011). The Text Line is well suited for a supportive role for texters struggling with the above the issues. Along with a mission to build rapport and create connection for texters, the emphasis in our texts includes active listening to help with emotion regulation, suicide assessment, creating linkages with other supportive adults and professional services, and development of positive coping skills and safety planning.

Texters also can "touch base" with us between appointments with service providers. This type of use of text is part of a growing trend in mental health, such as in contacts between treatment with low SES clients dealing with depression using CBT (Aguilera & Muñoz, 2011), helping clients feel connected and keeping appointments with therapists after psychiatric

hospitalizations, (Vernig & Repique, 2015), between appointments with crisis clients (Furber, Jones, Healey & Bidargaddi, 2014) and more.

Some especially vulnerable texters have checked in with us in between hospitalizations, and along with helping them stay in their community, we also have helped them decide whether they need a higher level of care temporarily.

Please see Appendix II for examples of returning texters as well as an in depth profile of an anonymized texter by Maya Earle, MFT, and Crisis Line Counselor.

American Association of Suicidology Conference Presentation

The Text Line Coordinator and the CSS Community Education Program Coordinator, Cristina Rita, presented a workshop "Understanding Non-Suicidal Self-injury for Text Counseling" at the American Association of Suicidology's annual national conference. This presentation developed out of the knowledge gained from many text sessions dealing with non-suicidal self-injury. The Text Line Coordinator and a Crisis Line Volunteer Counselor, Jaya Roy, created a class for text line counselors dealing with NSSI in collaboration with the CSS Community Education Department.

Youth Ambassador Program – Quest Project

This year, as in past years, the Text Line Program benefited from a local high school's senior year community "Quest" service project. Seven high school seniors came for multiple meetings with the Text Line Coordinator at CSS to learn and exchange information with the Text Line Program. Their focus was youth suicide prevention, youth depression, bullying, and gun violence prevention as it relates to school shootings. The students were helpful as a teen focus group for the Text Line Program.

Not only did the students provide great feedback for Text Line counselors (for instance: "don't use an exclamation mark with bad news – as in 'That's so sad!" but do use single exclamation marks with happy news – "how awesome that you got an A after you worked so hard!'") but they also helped create the framework for a new program that we aim to implement next year, the CSS Text Blast Project. EMS has the capacity for us to send out text messages ("text blasts") in one way format to large groups of texters. The messages would be designed to support positive mental health behaviors, with helpful links and/or reminders for self-care. The idea is to send messages created by youth for youth.

The students created the auto messages to go out when youth will opt in to the program and created over 30 positive messages informed by mental health related reading material assigned by the Text Line Coordinator. Examples of messages developed by the students:

"Do you worry a lot? Pick a time period for a 'worry session' and put off worrying thoughts until that time."

"It's okay to not have things figured out. Just remember to be kind to yourself."

The students found the work helpful for the completion of their projects as well as for their personal development:

"The project not only helped me understand troubled teenagers better but also helped me as an individual. The stress management skills, positive self-talk tips,

and interesting topics we talked about with other QUESTers were fantastic in shaping my own mental welfare." – Quest Student

"Throughout the course of this project I have learned a lot about helping teenagers with suicidal thoughts and depression as well as how beneficial the text line is to this new generation of tech savvy teenagers… I am extremely excited to see how the text blast program works out because, as we had discussed during our service meetings, receiving random messages would truly add to a random spark of positivity in an individual's day." – Quest Student

Switch From Short Code 839-863 to Short Code 20121

This year our Text Line Program software provider, EMS, had to switch our short code, as the company they rented the 839-863 short code from was sold. The good news is that the new short code has historically been used by child welfare and mental health agencies and major cell carriers don't charge when people text to 20121. This also means that there is more confidentiality, as the number will not show up on itemized bills.

COMMUNITY LINKS

Next year will be an important year for expanding on existing linkages with other agencies serving youth in Alameda County. In addition to the important mission of letting agencies know our short code number has changed, we will also open up the conversation about what the challenges are for the agencies' particular populations. We will ask about appropriate resources and referrals for their populations and helpful interventions.

YOUTH INVOLVEMENT

The Text Line will be looking to expand on the youth involvement, including further developing and launching the Text Blast Project. It may be a fit to work with an agency that already serves youth in Alameda County.

PREPARE FOR EXPANSION OF POPULATIONS

If the trend of text continues in the general population, counselors may begin to see more Alameda County TAY and adults texting in. In addition, we may see more hearing impaired people use the service. Often our target population is on social media, which has no geographic boundaries. As a result, we are receiving more out of county texters. We strive to connect them to their local resources, but we will likely continue to be challenged by this.

OUTCOME MEASUREMENTS

We want to continue to measure the success of our program. The Text Line Coordinator is working on creating an anonymous post text survey to offer texters after a session. We hope to be able to report on the results in the next fiscal year report.

Report created by Karen Oberdorfer, Text Line Coordinator, July 1st, 2015

Aguilera, A. & Muñoz, R., (2011) Text Messaging as an Adjunct to CBT in Low-Income Populations: A Usability and Feasibility Pilot Study. Professional psychology, research and practice, 42(6): 472–478. doi: 10.1037/a0025499

American Association of Suicidology, Suicidal Behavior Among Lesbian Gay Bisexual, and Transgender Youth Fact, Sheet http://www.suicidology.org/ncpys/resources

CDC, The Relationship Between Bullying and Suicide: What We Know and What it Means for Schools, http://www.cdc.gov/violenceprevention/pdf/bullying-suicide-translation-final-a.pdf.

Frieden, T., Steve Kinchen, S., Shanklin, S., et al., (2014) Youth Risk Behavior Surveillance — United States, 2013. *Morbidity and Mortality Weekly Report*, 2014;63(No. 4).

Furber, G., Jones, M., Healey, D., & Bidargaddi, N. (2014) A Comparison Between PhoneBased Psychotherapy With and Without Text Messaging Support In Between Sessions for Crisis Patients. *Journal of Medical Internet Research.* 16(10): e219. doi:10.2196/jmir.3096

Lenhart, A., Pew Research Center, April 2015, "Teen, Social Media and Technology Overview 2015"

Siegel, D., (2013) *Brainstorm: The power and purpose of the Teenage Brain.* New York: Penguin Group

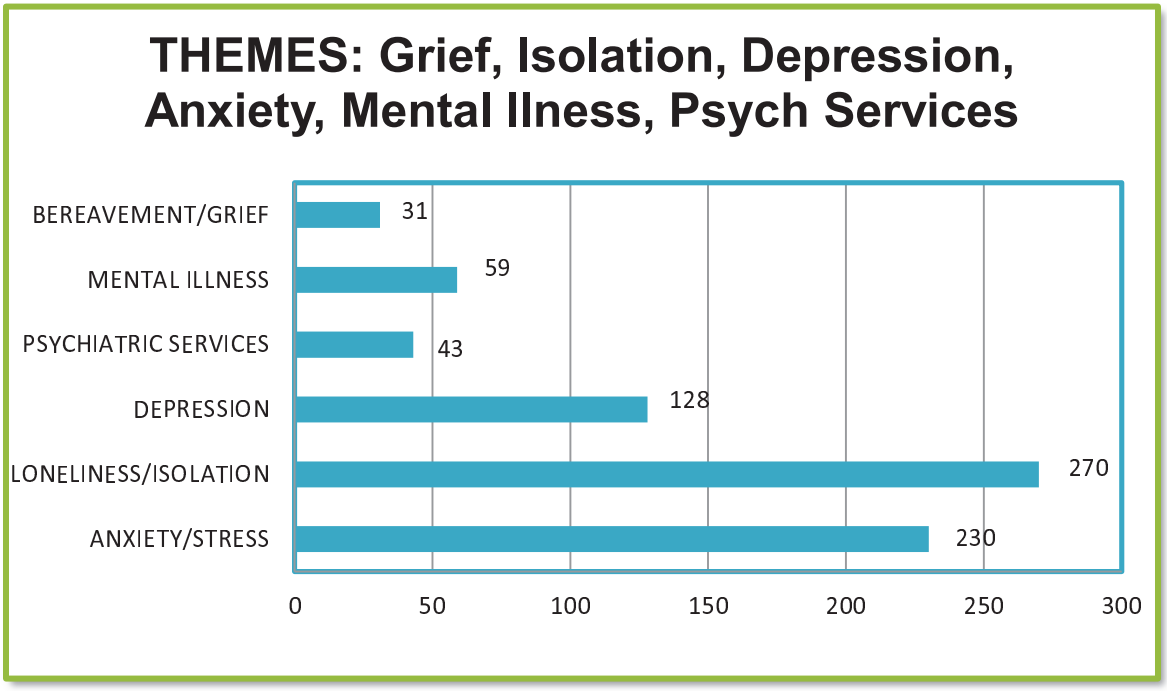
Sullivan, E., M., Annest, J., Simon, R., Luo, R., & Dahlberg, L., (2015). Suicide Trends Among Persons Aged 10–24 Years — United States, 1994–2012. *Morbidity and Mortality Weekly Report,* 64(08);201-205. http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6408a1.htm

Vernig, P. & Repique, R., (2015) Short Message Service Can Be a Promising Tool for Psychiatric Patients and Clinicians. *Journal of the American Psychiatric Nurses Association,* Vol. 21(1) 31–33, DOI: 10.1177/10783903145668

APPENDIX I

Themes of Texts: Anonymized Examples

What follows are examples of themes. They have been loosely grouped into 4 charts, but the groups are not always directly related and some sessions had several themes across charts.



Bereavement/Grief :

TEXTER: *"One of my friends killed herself and school is really hard and I don't see a point in the future, everything feels so hopeless"*

Mental illness: 59

TEXTER: *"So basically I have ADD and I feel like my parents dont understand and whenever my mom talks to me I have to ask her what she said"*

Psychiatric Services: 43

TEXTER: *Hello my son is just home from a hospitalization. Today is his first night home. He does not to take the medication and has new small cuts on his leg from a pen and I am hoping he will talk to you.*

Depression: 128

COUNSELOR: "*That sucks not to be heard at first by your therapist, but it's so good you persisted and let her know what was happening!*"

TEXTER: *"I feel like she didn't really believe me when I said that I was feeling depressed. They thought it was environmentally caused and I just didn't agree. I feel like she didn't realize how serious things were until I told her about the drinking"*

SUB THEME – How depression and other feelings can be masked, but come out with us as a first step to seeking help:

TEXTER: *"Its like a long roller coaster and the lows go so down low, I completely ignore my friends and teachers and lie saying that I'm fine, just tired. But really, I am tired. Tired of feeling so depressed."*

Loneliness/Isolation: 270

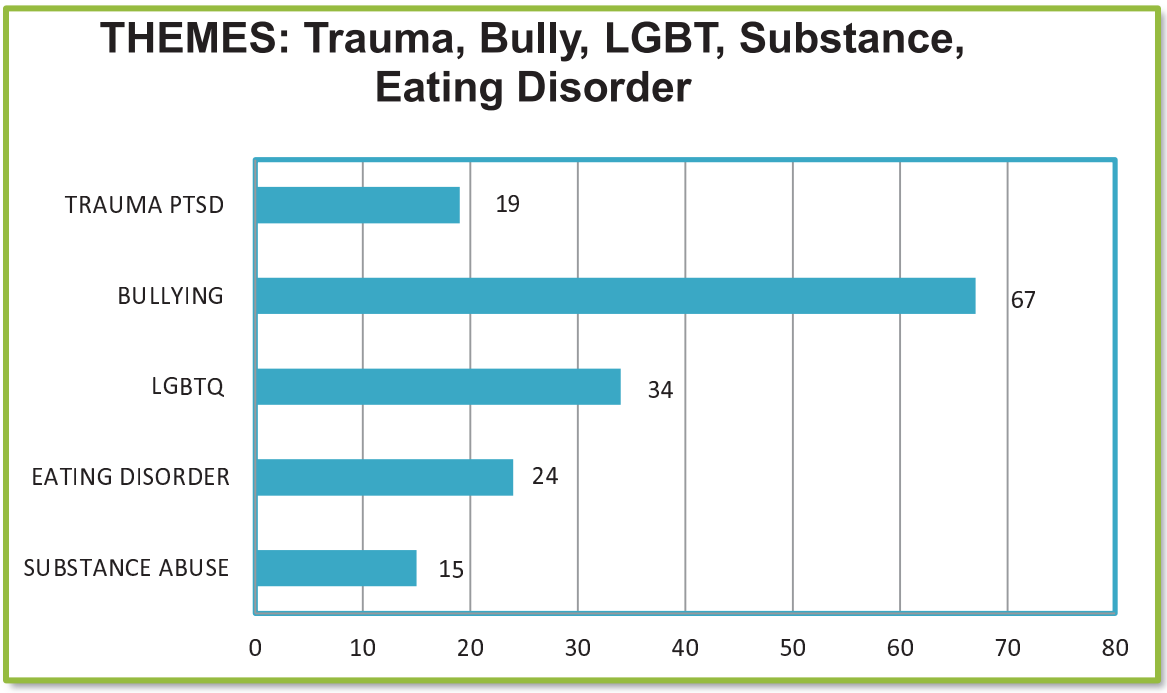
TEXTER: "*No I'm not feeling suicidal. I'm extremely depressed. I have only one friend, and our friendship isn't even that close. I used to be able to make lunch plans every week but now I find myself eating alone most days."*

Anxiety and Stress: 230

TEXTER*: "I'm giving a speech about being yourself and gay rights and I'm terrified and it's stressing me out"*

COUNSELOR: *"yeah giving speeches can be really scary. What about it is stressing you out?"*

TEXTER: "*I'm scared because I'm gay but only open to close friends and family and I'm scared of what they'll think about my speech"*



Trauma/PTSD: 19

NOTE RE TRAUMA: Only a small number of text sessions were coded for trauma, but based on some texters' life situations and presentations it is likely that more texters were dealing with trauma but did not mention it in session. Also of note: certain high intensity themes often come in clusters – during this particular session there were themes of: NSSI, past hospitalization/psych services, family relationship strife, and trauma.

> TEXTER: "*Can I bring up something else real quick. .....?*"
>
> COUNSELOR: "*Absolutely*"
>
> TEXTER: "*OK so in a week about, I'm going to be testifying in court against the person that sexually abused me*"

Bullying: 67

NOTE RE BULLYING #'S – one reason we had so many bullying codes is that one texter, who texted frequently, who was struggling with bullying on a regular basis. The example below is not from that texter.

> TEXTER: "*In english class this boy and his friends threw a condom packet at me and I just ignored it and laughed it off and I was doing my work and then he kept saying to pick it up and I didn't know he was talking to me and then he was all like you're so rude and it made me feel bad about my self I was sad the whole day like they called me names and said I was rude*"

SUB THEME: Cyberbully:

COUNSELOR: *Wow, they are mean. What site is it?*

TEXTER: *Xanje. But I'm pretty used to it*

COUNSELOR: *That sucks that you're used to it! Cyberbullies can be so stupid. What do you think you're going to do about it?*

TEXTER: *Tell them off*

COUNSELOR: *What will you say that's clear and more mature than them?*

TEXTER: *I'm going to say it's a public site and I'm allowed to be free and speak my mind as long as I'm not rude and immature like they are*

LGBTQ: 34

EXAMPLE A: TEXTER: "*its so hard became i dont make friends that easy and im just so different and im a lesbian and just i know my mom won't accept me*"

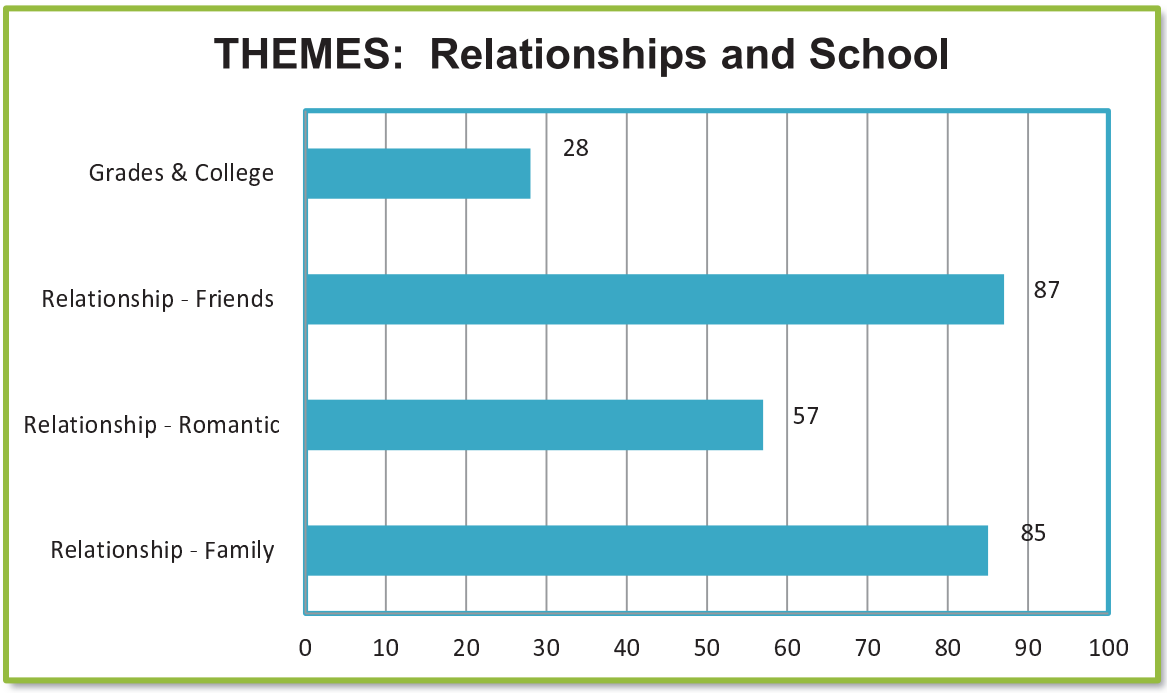
EXAMPLE B: TEXTER: "*To make this situation even more complicated, I'm transgender and I identify as a girl*"

Eating Disorder: 24

TEXTER: "For the last 2 nights I have been making myself throw up after lunch and I have been feeling fat"

Substance Abuse: 15

TEXTER: "*I just have these emotions and I don't really know how to deal with them. They come up during school, in the middle of the night. Nothing brings instant release. I take sleeping pills or drink but it doesn't work forever*"



Grades & College: 28

TEXTER: "*its been going on for about a week. I just suddenly became really upset like I didn't want anyone near me. I'm not sure of the cause but I think I'm stressed over school and my grades*"

Relationship: Friends 87

TEXTER: "*I'm just feeling sort of lost*"

COUNSELOR: "*gee, that sounds really hard. do you want to tell me a bit more about what's making you feel that way?*"

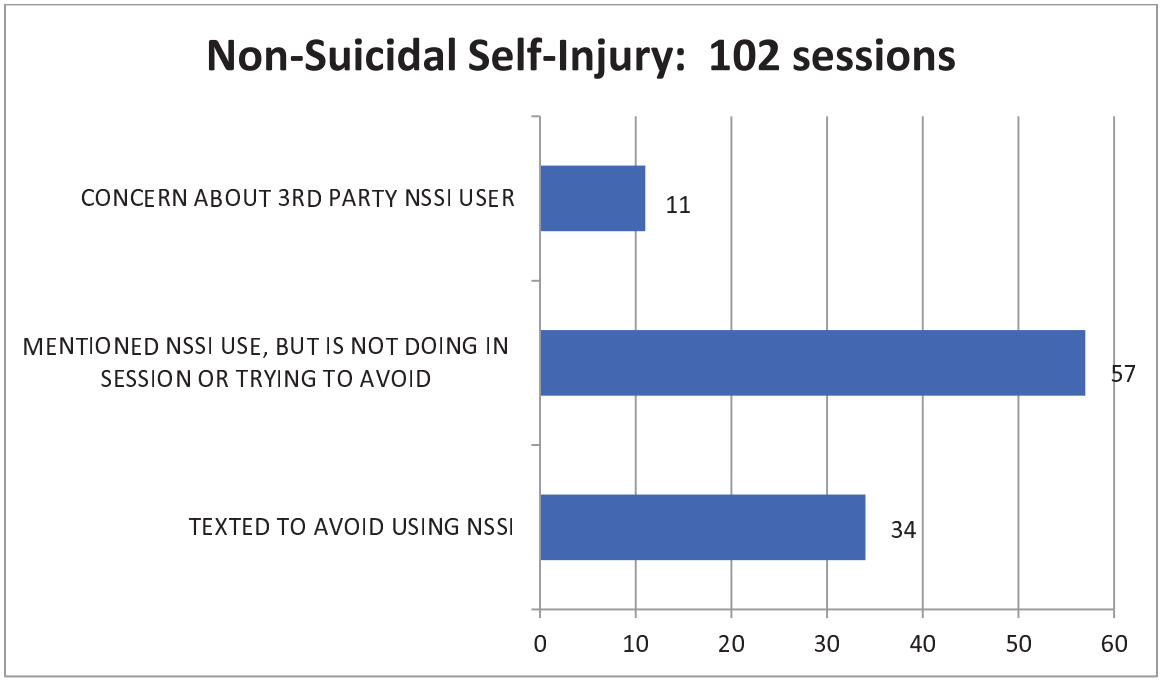
TEXTER: "*I don't quite know, it's just been alot, I just don't know what I'm doing anymore,I don't know what I want to do, all my friends stopped hanging out with me*"

Relationship: Romance 57

TEXTER: "*We've been broken up for a month and it was a pretty nasty breakup*"

Relationship: Family 85

TEXTER: "*Yeah and since my brother moved to college last year I just feel so pressured by my parents to do more now that my brother is gone*"



This Fiscal Year we only coded 102 Non-Suicidal Self-Injury (NSSI) related sessions, approximately 15% of the total text sessions. This does not mean, however, that some sessions may not have been with texters who use NSSI to cope, but only that there was no mention of it. Below are examples of NSSI themes we found when coding:

NSSI: Concern About a 3rd Party: 11

TEXTER: "*Yes during her history class period she was crying. Then after school she asked me how do u cut urself?, and how will u bleed? I didnt answer I was very speechless on what she just asked me.*"

NSSI Mentioned, but Not Doing at Time of Text, nor Trying to Avoid During Session: 57

Example A: TEXTER: "*I have not. Though I did feel the urge to, I find that using a marker an drawing where I want to cut satisfies that urge and makes me feel better*"

Example B: TEXTER: "*I was just texting my boylfriend and he just sounded troubled.. he said things that upset me and I just don't feel comfortable and felt like cutting but I didn't*"

Texted to Avoid NSSI Behaviors: 34

TEXTER: "*Well when I first started self harming (like a year ago) I had it under control and could stop whenever I wanted to, and would only do it every few weeks or so. Now it's like I can't not self harm and do It 1 or even 2 times a day and don't really have "control" over it*"

COUNSELOR: "*That must be scary. Not feeling in "control" is a very stressful place to be. I am so glad you reached out to text tonight.This is a safe place to have a real talk about what is going on. Are you self harming now?*"

TEXTER: "*No I was going to but then I texted you guys*"

APPENDIX II RETURNING TEXTERS EXAMPLES

Example A: Between hospitalizations

Here is an example of an interaction with a suicidal texter who had been hospitalized before and was beginning to feel intense symptoms:

COUNSELOR: *"Do you think you might need to go back to some kind of in patient for awhile? In meantime I want you to know you can check in with us whenever we're open for texting - 4pm - 11pm. We can be a part of your support network."*

TEXTER: *"Maybe I do need something inpatient, but I'm scared."*

During the rest of that session they explored the fear (asking for help). At the end the counselor offered to outreach to them the next day and the texter agreed. The next day, the texter reached out to the Text Line on their own at the start of the shift.

In the case of ongoing struggles, such as with NSSI and depression and low self-esteem, we have been a place where texters can touch base for a booster, remind them of their coping mechanisms and help avert a drift towards a new crisis.

What follows are several examples of "regular texters":

Example B: Sub acute, chronic stressors

One texter, we'll call Rae, texted in over 45 times during the year. In many cases the themes was the same and all related to issues that people struggling with depression experience: isolation and loneliness, low self-esteem, and feeling that they are incapable of expressing themselves, which heightened feelings of isolation: "*yeah I'm kinda the type of person where I can't really express my feelings.. I get kinda scared and nervous with like anybody expressing how I feel and what's really going on..my guard is always up*" – Rae.

The suicide ratings for all the sessions were at a "0" and Rae was often assessed for NSSI (one hallmark is overwhelm and "bottling up" feelings (reference here) yet always said they did not use NSSI for coping "*yeah I keep everything in and i seriously mean everything* ".

Rae's distress levels at the beginning of the sessions mostly ranged from 0 to 2. The change was often minimal. Yet this texter is able to use us as a stabilizing force and has begun to develop coping skills and has been repeatedly encouraged to seek therapeutic support in addition to our support. As with some texters with low self-esteem and others stressors, Rae would vacillate between feeling entitled and emboldened to seek support and at other times not.

COUNSELOR: I'm glad you can come to us for an outlet. You deserve to express yourself! do you talk with a therapist at all?

RAE: thanks and no

COUNSELOR: that could be helpful as it's another non-judgmental person to speak with about what's going on

RAE: that makes sense

COUNSELOR: expressing yourself is difficult. It takes a lot of practice and making yourself vulnerable but you're practicing already by texting in

RAE: really?

COUNSELOR: absolutely! you're talking about emotional stuff with a stranger that shows strength and willingness to express yourself :)

RAE: I never thought about it like that

During sessions counselors assessed for positive coping skills. Rae cited music, sleep and writing as helpful, which they had stopped doing but said they had restarted doing after several encouraging text sessions.

While each session has similar themes, many sessions now also include affiliative, connected moments: "*thank you for your help :)* ". There is little movement in the traditional sense, but the texter's main complaint about a dysfunctional relationship and trouble communicating, is not experienced with us. The meta-message is that Rae can have balanced relationships, can express themselves and their needs and therefore beat isolation, and can be concerned about taking care of their own needs and deserves to think about and incorporate healthy coping skills into their life.

Example C: Recent suicide attempt

Another texter, "Piper", first contacted the Text Line after they had made a suicide attempt a few days before. They were not hurt badly, nor hospitalized, but it was a "wake up call" for them. They did not tell anyone about it first, except us. This was their first experience seeking help. Over the course of the year they opted in 17 times and had 11 complete sessions. The other times they either opted in off hours, or immediately opted out. Themes of suicidality, NSSI, depression, and relationship strife with family were present in their sessions.

During their sessions they were encouraged to also reach out to school counselors and their parents. Counselors also explored positive coping mechanisms, including drawing and listening to music. "*If I feel bad for any reason, I have my coping mechanisms. Thank you for giving me someone to talk to Sandra, you really are helping. Thank you so much*"

Piper said that they would reach out to us if ever they felt they were suicidal again. "*That's why I've been trying to check in with the hotline because you guys are a big help to me and keep me from doing anything I might regret.*" – Piper

Account of a Returning Texter by Crisis Line Volunteer

The profile below, By Maya Earle, LMFT, has been anonymized. In the following profile the texter is described as "they". We studied this texter specifically because they returned regularly for support. As is common with high distress texters, they presented with clusters of themes: NSSI, Mental Illness, Relationships, Eating Disorder, Abuse, and Substance use.

"Juno" by Maya Earle, LMFT.

This is a summary of the themes present in the texts of "Juno", a single teenage texter, as they developed from 2014 to 2015. It is an exploration of how they have shifted in the course of their conversations with the text line. Over time Juno indicates more trust, more willingness to seek professional support, a shift towards being more self-aware about their NSSI, and importantly, an ability to reflect on their coping skills and use them when most needed.

Juno's texts in the summer of 2014 express that they are "*not doing well*", and they respond to additional questions with primarily one word answers. They engage with the safety assessment but have difficulty coming up with things that would be helpful to them, often stating "*Im not sure*" when asked about how they cope with their feelings. Over time, Juno begins to report more specifics, such as depression and paranoia, but does not readily answer text counselor questions, and would ask for a female counselor if possible. Their texts come across as confused, and are limited in content other than stating their distress.

After several sessions of talking to a text counselor Juno starts to text about experiencing *"... really bad depression and anxiety and I see things and hear things I'm super paranoid and stuff like that."* It is still difficult for them to go into detail about these serious topics and even though they mention feelings of suicidality and their own cutting behaviors more readily than in first sessions, they do not go into great detail. When asked more directly whether they feel like it would help to talk more, they respond "*No not really,*" yet they continue to text back to the Text Line.

Juno's attitude towards viewing themselves as actively being able to soothe themselves is one of the most pronounced shifts in their texting. After several months, Juno begins to talk about their emotional experience in the context of their family and self reflects on how their

coping mechanisms, such as cutting and smoking pot, are both good and bad for them. They have begun talking about their own experiences, but still are not ready to explore what they could to help themselves. They express that they are "*not sure*" what would be helpful to talk about.

Juno's attitude towards viewing themselves as actively able to soothe themselves is one of the most pronounced shifts in their texting. In only four months Juno, completely independently, offers in a session that "*I only have 2 coping mechanisms and one of them is bad and the other one I can't do*". Although still an expression of frustration, this is a significant shift for Juno, as they shifted from single word responses and difficulty tapping into their coping skills, to being able to both engage with the counselor and self-reflect on their abilities to handle their feelings. They begin to assess for themselves whether or not smoking "weed" is a helpful coping mechanism for anxiety. It is an amazing shift to see them move from stating "*I cut*" in earlier sessions to "*My self-harm that has gotten really out of control lately*" a few months later. They reflect not just on their own desire to cut, but also the frequency and their level of perceived control over their cutting. Their sense of their coping mechanisms also becomes more hopeful, branching into activities that are in no way harmful to them: "*The only other thing I have to do is just distract myself with listening to music".*

They also begin to explore underlying family issues several months into their texting, and talk less about their paranoia and more about a potential underlying eating disorder. They still talk about their suicidality, and are able to explore their own reasons for these feelings by bringing in their physical pain, and family related anxiety. Juno also begins to explore other social supports with the text counselor, such as friends, and potential therapeutic support.

COUNSELOR: "*That's good. Are you interested in professional help? Do you have a therapist?*"

JUNO: "*I would love professional help but I don't have a therapist*"

Along these lines, Juno begins in general to use the text line to ask practical questions about whether they should get a medical marijuana card, how to get a therapist, what the symptoms are of ADHD and the treatment, and what their rights are as a person under eighteen. From an outside perspective it appears that they have shifted from a stance of suspicion of the text counselors to that of trust. They also text in on behalf of another person on the internet who they believe is suicidal, indicating that they have found this resource helpful and trust the line to help with suicidality. They state "*Ok I'm just really scared for her. I gave her your guys #".* Another indicator of trust is that Juno also begins to text the line in the midst of more difficult situations, texting when they are fighting with a parent, while their friend is relapsing, and when they are worried they are going to do something to hurt themselves.

Perhaps one of the most important changes in their patterns of texting is that in the first few months Juno had only texted after they had cut themselves, however in later texts they contact the line before they have cut, admitting to a strong desire to do so. They had made a shift from using the text line as a secondary coping mechanism after they had completed their cutting

to using it as one of their primary coping mechanisms before cutting. Juno states at a certain point when asked if they have already cut that "*No I was going to but then I texted you guys*"

It also seems relevant to point out that in the first months of Juno's reaching out to the crisis line they do not report a change in mood at the beginning and end of text, however by seven months into texting the line they more frequently state "*I'm feeling better*" by the end of a session. When asked if there is anything else they want to talk about in one of their later sessions they reply "*No*" but this time follows it with *"...but thank you for helping me tonight*."

APPENDIX III Text Counselor Feedback – QUOTES:

"What I like best about text counseling is that it offers the counselor more time to craft a response/question than a phone call normally allows. I would like to think it translates to a more powerful experience for the youth." – CSS Crisis Line and Text Line Volunteer

Shift supervisors took an active role in text counseling and supervising volunteer Text Line counselors. They continue to find texting challenging and rewarding:

I appreciate that the text line gives teenagers a space to approach us in a way that is comfortable for them. It gives them the power to guide the conversation without being pressured, and that gives them the confidence to open up to us. It helps build rapport and encourages them to continue to text us in the future. – Neal Aneja, Shift Supervisor

Being a text counselor means reaching teens that might otherwise not feel comfortable calling us. Speaking with them via their preferred medium feels like saying "I am here for you" before we ever exchange a word. The text line seems to be a great source of comfort for teens who are looking for ways to help friends who are feeling suicidal. Clearly we are reaching more than just the teens who are texting us. Text counseling has caused me to reflect more on how I express empathy whenever I am counseling someone. – Sara Hood, Shift Supervisor

I noticed how I can be in front of the class during a presentation and see that the class is quiet and not saying much, but I can tell who might be impacted in their personal life by some challenges around this subject. I enjoy being able to tell the students that this service was developed for them especially. It's been inspiring to be here at 4:00 when the text line shift starts and know most likely that the people texting in for the first time on that shift may have been at a presentation with me or another TFL presenter. Kate Eisler – Shift Supervisor and TFL Presenter

What I like about using text is the barriers to entry seem a lot lower. Youths can text us on the fly, if they're on break from school, if they're at dinner with their parents, if they have a quiet moment at home. Because of that, it feels like we can be with teens when they're at their moment of most immediate need, far different from talk therapy or even phone counseling. It's influenced my counseling style by making me become a lot better at giving people space to talk. Teens can have their guard up a lot, I've found it helps to disarm that by becoming the opposite of a helicopter parent, being sincere, engaged, but also prompting them to talk about their lives, rather than bombarding them with questions or advice. It's good practice. – Will Gutierrez, Shift Supervisor

The youth population is often more reluctant to reach out for help, so this makes it all the more important to create a tool for them to get support that accommodates them "where they are". Text counseling is accessible and non-threatening and allows teens who otherwise would be alone with their struggles to speak with someone who is older and can offer them perspective. It is important for teens to feel heard and to be reminded that what they are going through is not totally unique, that other

people have been in similar circumstances. The text counseling technology allows us as counselors to really analyze how we did and adjust our techniques based on how well things worked. It is also a method that allows for counselors to cooperate with each other when working with a client. – Asa Kamer, Shift Supervisor

I definitely feel like it's expanded my counseling skills, expanded my ability to "listen" and gather information. The process itself is different in a variety of ways: you're working with a population that's really fast, yet the actual process is slow and yet you're gathering a lot of information at times. It can be challenging assessing and exploring feelings typing but I think it can be better serving for texters because they're seeing their words, which is processing what they're thinking in more ways than just saying it over the phone. I think it can be challenging at times, but it can also be really rewarding. Just like for the texter, I'm also processing differently, too. –Tamia Slyter Shift Supervisor

Appendix 4 Article

https://oaklandnorth.net/2014/09/16/meeting-teens-where-they-are-suicide-prevention-by-text-message/

CRISIS SUPPORT SERVICES of Alameda County

Clinical Program 2014-2015 Annual Report

Total Clients Served and Client Demographics

224 School Based Counseling Students K-12

172 Older Adults (26 funded in part by the Area Agency on Aging)

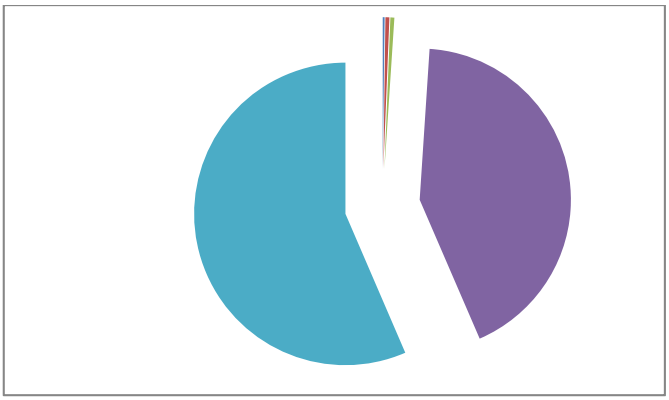
82 Grief Counseling Clients

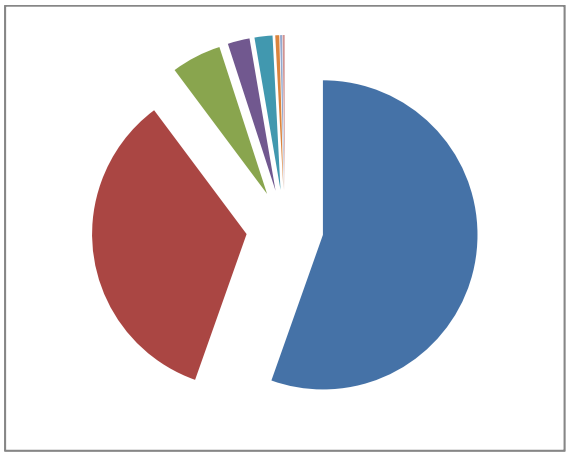
478 Total Clients

Gender

270 Female Clients
203 Male Clients
2 Non-binary Clients
2 Transsexual Clients Male to Female
1 Client Declined to Answer or Un-noted

478 Total Clients





Sexual Orientation

266 Heterosexual Clients
165 Clients Declined to Answer/Not Asked*
25 Gay Clients
11 Lesbian Clients
9 Bi-sexual Clients
1 Pan-sexual Client
1 Questioning Client

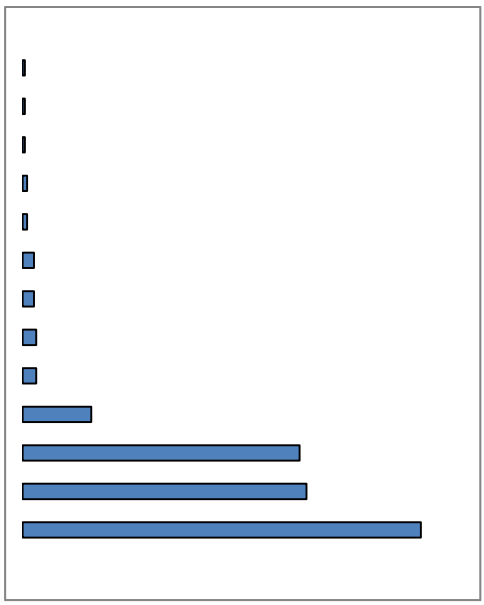
478 Total Clients

* 77 or 47% of students not asked aged 5-11

(2)

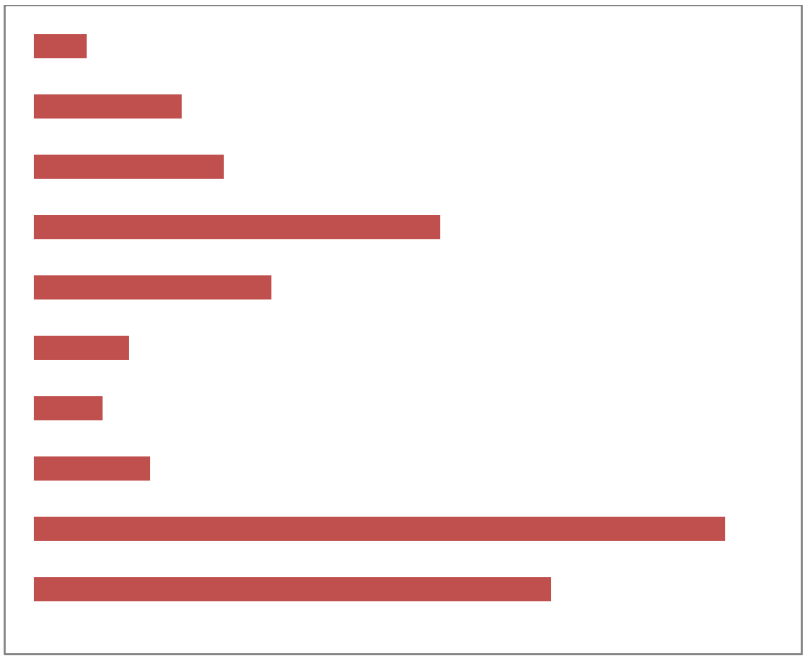
Ethnicity

1 East Indian Client	-1%
1Japanese Client	-1%
1 Client Self-identified as Other	-1%
2 Pacific Islander Clients	-1%
2 Afghani Clients	-1%
5 Chinese Clients	-1%
5 Vietnamese Clients	-1%
6 American Indian Clients	1%
6 Filipino Clients	1%
30 Clients Declined to Answer or Not Asked	6%
121 African American Clients	25%
124 Hispanic Clients	26%
174 Caucasian Clients	36%
478 Clients	100%



Age

10 Clients	2% aged 89+
28 Clients	6% aged 79-88
36 Clients	8% aged 69-78
77 Clients	16% aged 59-68
45 Clients	9% aged 49-58
18 Clients	4% aged 39-48
13 Clients	3% aged 29-38
22 Clients	5% aged 18-28
131 Clients	27% aged13-17
98 Clients	20% aged 5-12
478 Clients	100%



(3)

Crisis Support Services (CSS) began as a nonprofit, volunteer-based crisis intervention and suicide prevention agency in 1966. For almost 50 years, CSS has provided a variety of mental health services to a wide range of persons in varying degrees of crisis.

To help meet the needs of at-risk Alameda County residents, CSS staff, are proactive participants in the development of and adherence to best practice modes of treatment, education and quality assurance. This past year, the agency embraced the ideals of Cultural Humility. Staff participated in a Cultural Humility, LGBTQI2 and continued our Trauma Informed Care trainings. Alameda County Behavioral Health provided several vital trainings at no cost to partner agency staff. CSS is committed to fully integrating these principles into the very fabric of everyday behaviors and business practices.

Our primary mission is to assist people in emotional distress, to offer supportive counseling to those in crisis and to prevent suicide. We accomplish this by incorporating evidence-based treatment. Trauma-informed approaches incorporate some or all of the following elements:

Establishing Safety	Defusing the Immediate Crisis
Building a strong rapport	Therapeutic collaboration
Normalizing trauma responses	Family and/or social support
Emotional regulation tools	Anxiety management tools
Strength and resiliency focused	Cognitive reframing and practice

As a training agency, CSS strives to ensure that all clients receive trauma informed, culturally sensitive, LGBTQI2 and outcome based mental health services. Below is our fall and spring training schedule. Attendance is required of all counselors (interns) providing direct services.

2014-2015 Fall Training Classes 36 Hours

Saturday	August 30	9am to 12:00	Orientation:
Saturday	August 30	1pm to 4pm	Clinical Programs Nuts and Bolts
Sunday	August 31	9am to 12:00	Counseling Older Adults Part 1
Sunday	August 31	1pm to 4pm	Greif Counseling
Saturday	Sept 6	9am to 12:00	Facilitating Groups
Saturday	Sept 6	1pm to 4pm	Establishing the Therapeutic Alliance
Sunday	Sept 7	9am to 12:00	Outcomes and Quality Assurance
Sunday	Sept 7	1pm to 4pm	Case Formulation and Treatment Planning
Saturday	Nov 1	9am to 12:00	Suicide and Depression
Saturday	Nov 1	1pm to 4pm	Counseling Adolescence
Sunday	Nov 2	9am to 12:00	Counseling Older Adults Part 2
Sunday	Nov 2	1pm to 4pm	Counseling Grade School Children

(4)

2014-2015 Spring Training Classes 42 Hours

Saturday	Jan 24	9am to 12:00	Attachment Part 1
Saturday	Jan 24	1pm to 4pm	Gerotranscendence
Saturday	Feb 7	9am to 12:00	Non-Suicidal Self-Injury (NSSI)
Saturday	Feb 7	1pm to 4pm	Substance Abuse and Addiction
Saturday	Feb 28	9am to 12:00	Attachment Part 2
Saturday	Feb 28	1pm to 4pm	Therapist Self-Care
Saturday	March 14	9am to 12:00	Trauma-Informed Care
Saturday	March 14	1pm to 4pm	DBT
Saturday	March 28	9am to 12:00	Co-Occurring Disorders
Saturday	March 28	1pm to 4pm	Gang Awareness
Saturday	April 18	9am to 12:00	Collaborative Counseling
Saturday	April 18	1pm to 4pm	Termination
Saturday	April 25	9am to 12:00	Suicide Assessment and Intervention for Mental Health Professional
Saturday	April 25	1pm to 4pm	Eating Disorders

In addition, all counselors are required to volunteer for one four hour shift per week on our 24 hour suicide prevention crisis line which includes another 45 hours of specialized didactic training.

CSS counselors in training are graduate and/or post-graduate students gaining hours toward licensure. We typically have a mix of pre and post graduates on the MFT, MSW, PCC, PhD and PsyD tracks. For convenience, we refer to all volunteer counselors in training as interns.

CSS is a highly desirable volunteer site for interns seeking expertise in suicide prevention, crisis intervention, post-intervention, traumatic loss, geriatric mental health and school aged child counseling. We typically receive over 200 new applications each spring for a fall placement. Once placed with CSS, interns may reapply for a second, third or fourth year. The majority of interns do reapply.

For the past few years, CSS has welcomed on average 12 new interns each fall. Here are a partial list of intern applicant schools; Notre Dame University in Belmont, Argosy in Alameda, The Wright Institute in Berkeley, The California Center of Integral Studies in San Francisco, CA State San Francisco, CA State East Bay in Hayward, JFK University in both Berkeley and Pleasant Hill and Holy Names University in Oakland.

30 interns served 478 clients for a total of 5419 sessions and an additional total of 2716 logistical and/or supportive telephone calls across all the clinical programs.

It would be impossible for Crisis Support Services to provide and sustain service to 478 at-risk Alameda County residents without our volunteer interns. And, we could not possibly provide the clinical training, mentoring, oversight and supervision of 30 interns without the 20 licensed supervisors who volunteer their time and expertise.

Many, but not all of our volunteer clinical supervisors were themselves volunteers on the crisis line and/or interns at Crisis Support when they themselves were gaining experience, training and hours toward their license. A review of their special training and expertise, mirror the skills needed to work effectively with the clients we serve.

Volunteer clinical supervisors meet weekly to provide individual supervision, training, mentoring, and oversight to their assigned intern(s). Clinical supervisors attend a monthly consultation group provided by CSS to review best practices and review intern performance.

Many supervisors also volunteer to teach intern classes in the fall and spring. Many are or were professors teaching in the field of mental health. All have private practices and all donate their precious time, adding their unique contribution to the mission of CSS to prevent suicide.

Interns attend weekly group supervision provided by the CSS Clinical Director. Interns also receive comprehensive training manuals which further detail best practice expectations in the field. Mandated reporting, client charting, case presentations, self-evaluations, evaluations by clinical supervisors, easy access to consultation, peer review, silent monitoring, and the clinical review of taped recorded sessions and monthly summaries of all client contacts support a culture of personal responsibility and professionalism required of a training agency serving at-risk populations.

As future clinicians of Alameda County, interns receive their most valued training directly from the clients they serve. By listening to clients, minimizing the potential for re-victimization, and holding true for each client the belief that full recovery is possible, interns to be trained to become what the client is needing. Collaborative, client driven and trauma informed clinical services begins with the very first phone call, the first session right through until the last session.

Utilizing Dr. Barry Duncan’s Session Rating Scale (SRS) at the end of every session, interns are able to determine the effectiveness of each session. This instrument was used with each client at each session. Please see adult (SRS) child (CSRS) and young child (YCSRS) versions respectively.

(6)

Session Rating Scale (SRS V.3.0)

Name _____Age (Yrs):____

ID# _____ Sex: M / F

Session # ____ Date: _____

Please rate today's session by placing a mark on the line nearest to the description that best fits your experience.

Relationship

I did not feel heard, understood, and respected. |----------| I felt heard, understood, and respected.

Goals and Topics

We did *not* work on or talk about what I wanted to work on and talk about. |----------| We worked on and talked about what I wanted to work on and talk about.

Approach or Method

The therapist's approach is not a good fit for me. |----------| The therapist's approach is a good fit for me.

Overall

There was something missing in the session today. |----------| Overall, today's session was right for me.

The Heart and Soul of Change Project

www.heartandsoulofchange.com

(7)

Child Session Rating Scale (CSRS)

Name _____Age (Yrs):____

Sex: M / F

Session # ____ Date: _____

How was our time together today? Please put a mark on the lines below to let us know how you feel.

Listening

_____ did not always listen to me.

_____ listened to me.

I----------I

How Important

What we did and talked about was not really that important to me.

What we did and talked about were important to me.

I----------I

What We Did

I did not like what we did today.

I liked what we did today.

I----------I

Overall

I wish we could do something different.

I hope we do the same kind of things next time.

I----------I

The Heart and Soul of Change Project

(8)

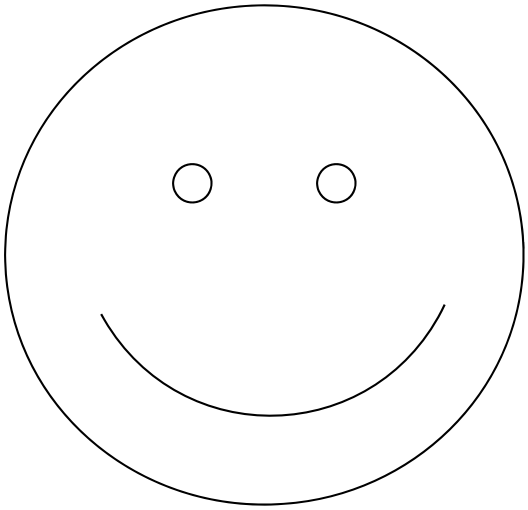
Young Child Session Rating Scale (YCSRS)

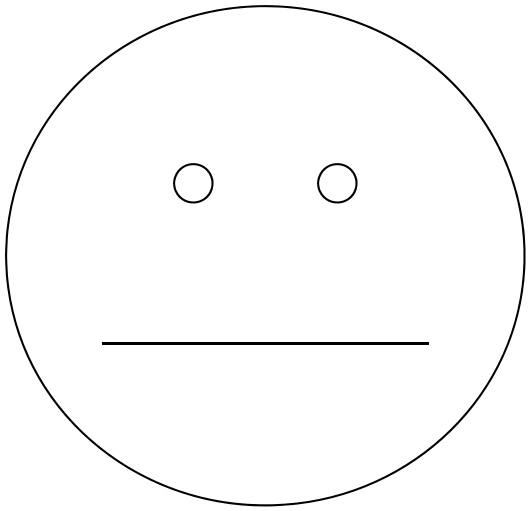
Name _____Age (Yrs):____

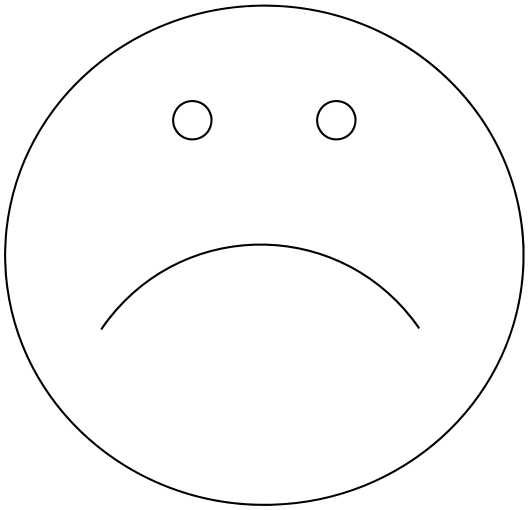
Sex: M / F_____

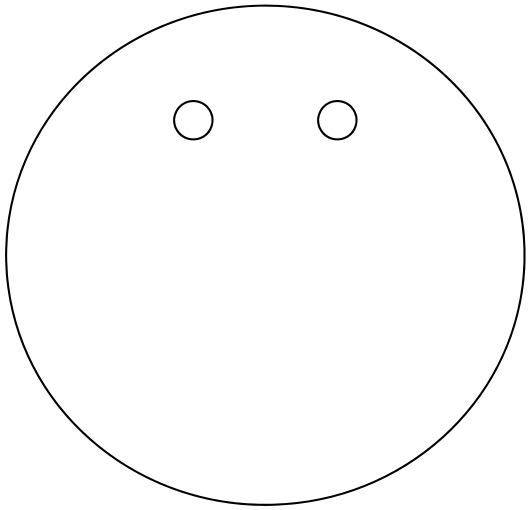
Session # ____ Date: _____

Choose one of the faces that show how it was for you to be here today. Or, you can draw one below that is just right for you.









The Heart and Soul of Change Project

www.heartandsoulofchange.com

K-12 School Based Counseling 224 Clients

	Clients	Sessions	Calls
Unity High-Oakland	81	1000	59
Hayward High-Hayward	53	514	55
Wood Middle-Alameda	4	6	6
Lorin Eden Elementary-Hayward	35	641	132
Maya Lin Elementary-Alameda	11	255	0
Henry Haight Elementary-Alameda	40	205	15
Total	224	2621	267

Ethnicity Code

W-Caucasian
AA-African American
H-Hispanic
AI-American Indian
FL- Filipino
VI- Vietnamese
AFG-Afghani
CH-Chinese
PI-Pacific Islander
O-Other
?-Declined to State/Unknown

Top Areas of Concern

Unity High	depression, anxiety, trauma, suicidal urges, anger, family discord
Hayward High	family discord, trauma, grief, academics, anger
Wood Middle	social skills
Lorin Eden Elementary	academics, depression, social skills, family discord, anxiety
Maya Lin Elementary	defiance, anger management, aggression, depression, anxiety
Henry Haight Elementary	social skills, emotional regulation, impulse control, aggression

Ethnicity	W	AA	H	AI	FL	VI	AFG	CH	PI	O	?	Total
Unity High	1	9	59	2							10	81
Hayward High	12	14	25						2			53
Wood Middle		1	2							1		4
Lorin Eden Elementary	4	8	12		2		1				8	35
Maya Lin Elementary	3	3	2		1	2						11
Henry Haight Elementary	13	12	9		2	1		1			2	40
Totals:	33	47	109	2	5	3	1	1	2	1	20	224

(10)

For school based clients, we utilize two instruments, Dr. Duncan's Outcome Rating Scale (ORS) below and our own Client Satisfaction Survey.

Outcome Rating Scale (ORS)

Looking back over the last week, including today, help us understand how you have been feeling by rating how well you have been doing in the following areas of your life, where marks to the left represent low levels and marks to the right indicate high levels. *If you are filling out this form for another person*, *please fill out according to how you think he or she is doing.*

Individually
(Personal well-being)

I----------I

Interpersonally
(Family, close relationships)

I----------I

Socially
(Work, school, friendships)

I----------I

Overall
(General sense of well-being)

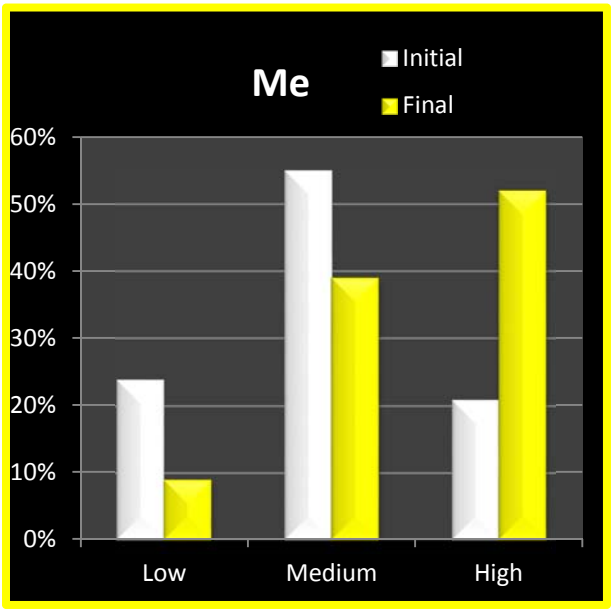
I----------I

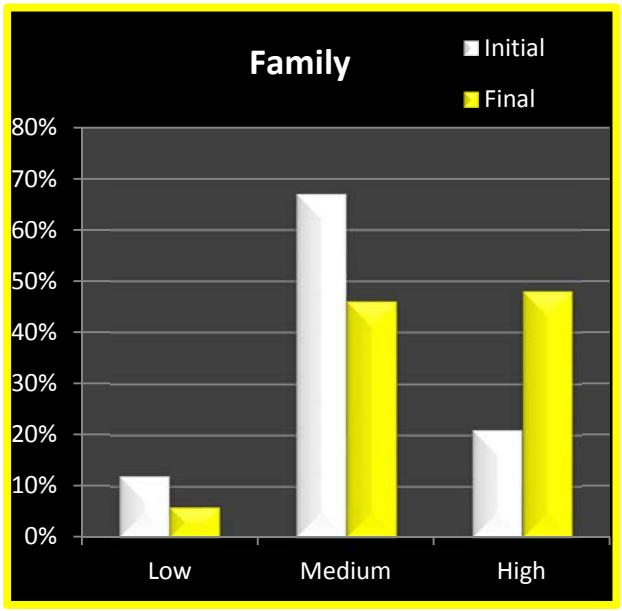
The Heart and Soul of Change Project

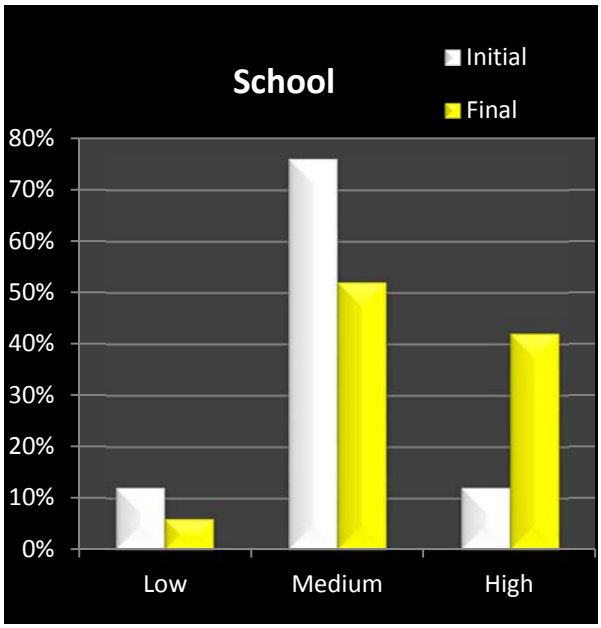
www.heartandsoulofchange.com

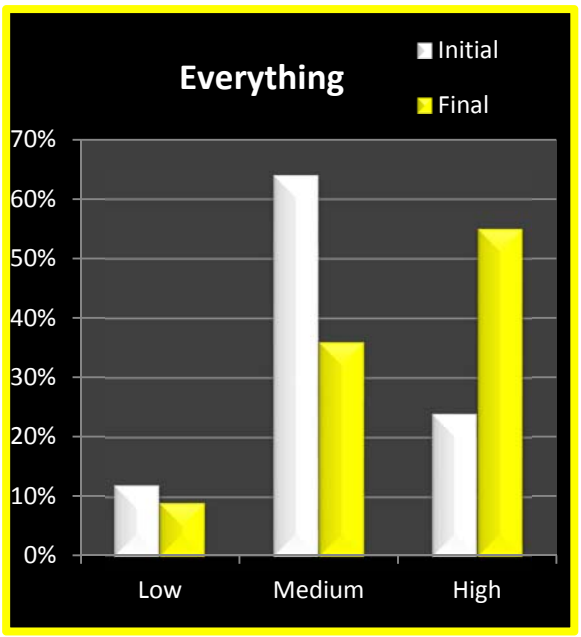
Students are invited to give a value to each of the four core areas of their lives each week. By comparing the initial value rating with the final value rating, a substantive outcome is generated at the conclusion of counseling. Using the Outcome Rating Scale in conjunction with the Session Rating Scale contributes to positive outcomes.

School Based Counseling Outcome Ratings









School Based Counseling Client Satisfaction Survey Results

For each statement, students were asked to put an X in the circle that best represents his or her experience with school counseling services. Surveys were returned by post or completed and given to their counselor at the last session. The table below left shows the answers chosen to items 1 – 11. The narrative to the right is a summary of comments and suggestions for improvement given by students when asked to, "Please write in any suggestions on how we might improve?"

1. Was the intake process (initial telephone contact, returning your phone calls, scheduling your first appointment, and so on) satisfactory to you?

Definitely No	Mostly No	Neutral or Unsure	Mostly Yes	Definitely Yes
0%	0%	50%	17%	33%

2. At your first appointment, was your counselor caring and respectful?

Definitely No	Mostly No	Neutral or Unsure	Mostly Yes	Definitely Yes
0%	0%	0%	0%	100%

3. Did your counselor help you form a realistic view of what you could expect from counseling?

Definitely No	Mostly No	Neutral or Unsure	Mostly Yes	Definitely Yes
0%	0%	0%	0%	100%

4. Did you feel safe and clear about confidentiality issues in your counseling?

Definitely No	Mostly No	Neutral or Unsure	Mostly Yes	Definitely Yes
0%	0%	0%	17%	83%

The students responding to the survey did not make any comments or suggestions.

5. Did your counselor act professionally (arrive on time, promptly return messages, and so on)?

Definitely No	Mostly No	Neutral or Unsure	Mostly Yes	Definitely Yes
0%	0%	0%	0%	100%

6. Was your counselor sensitive about and responsive to issues of diversity and culture?

Definitely No	Mostly No	Neutral or Unsure	Mostly Yes	Definitely Yes
0%	0%	17%	17%	66%

7. Did your counselor help you clarify and work toward a goal or goals in your counseling?

Definitely No	Mostly No	Neutral or Unsure	Mostly Yes	Definitely Yes
0%	0%	0%	33%	67%

8. Did you feel you accomplished what you wanted to in counseling?

Definitely No	Mostly No	Neutral or Unsure	Mostly Yes	Definitely Yes
17%	0%	0%	17%	66%

9. Overall, were you satisfied counseling?

Definitely No	Mostly No	Neutral or Unsure	Mostly Yes	Definitely Yes
0%	0%	17%	0%	83%

10. If you never used the telephone crisis line, please check here □ and skip this question. If you used the crisis line, did you find it helpful?

Definitely No	Mostly No	Neutral or Unsure	Mostly Yes	Definitely Yes
0%	0%	100%	0%	0%

Question 10: One student responding to the survey utilized the crisis line.

11. If you never used the text line, please check here □ and skip this question. If you used the text line, did you find it helpful?				
Definitely No	Mostly No	Neutral or Unsure	Mostly Yes	Definitely Yes
0%	0%	100%	0%	0%

Question 11: One student responding to the survey utilized the text line.

12. Would you refer a friend to Student Counseling?				
Definitely No	Mostly No	Neutral or Unsure	Mostly Yes	Definitely Yes
0%	17%	17%	17%	49%

CSS interns also provided a number of Student groups:

- Hayward High- Grief Group
- Lorin Eden-Girls Social Skill Group
- Henry Haight-Boys Social Skills Group

Providing therapeutic services to students at school reduces barriers to mental health treatment that may occur due to stigma or lack of resources. Students who receive attention for their mental health needs often improve their attention and ability to learn and have fewer referrals for disciplinary reasons.

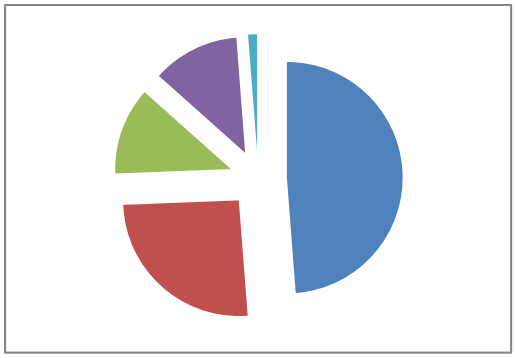
Our interns provide individual and group counseling to an increasing number of children, many of whom are depressed and at risk for self-destructive behavior and/or suicide. Often these students are dealing with loss and trauma in the wake of violence, substance abuse, family discord, parental incarceration or lack of parental support. Our counselors play an important role in providing assessment, referral, consultation and ongoing supportive counseling.

Angel, a 16 year old male, used talking, art, exploration of emotions and EMDR to work through his grief, early trauma and current trauma. He told his counselor at the end of the school year that he “didn’t believe counseling could help, but it did.” The intern noted that Angel was able to complete the school year and graduate on time.

CSS will be increasing the number of at-risk students we provide services to in the 2015-2016 school year. We were approached by a number of schools requesting crisis intervention and preventative supportive counseling services, all hoping to partner with CSS. We chose two new sites and are very excited to work with Emeryville K-12 and Unity Middle School students, their families and school staff.

Grief Counseling 82 Clients

Cause of Grief

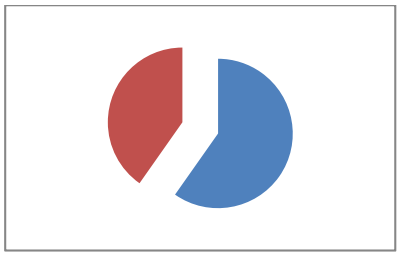


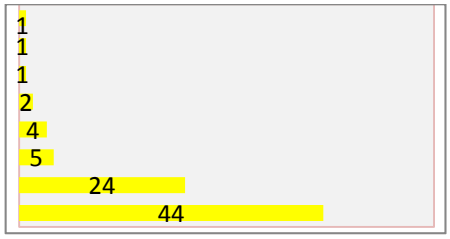
40 Deaths due to suicide
21 Deaths due to natural causes
10 Deaths due to homicide
10 Deaths due to a sudden traumatic event
1 Anticipatory grief client

82 Clients

Top Areas of Concern	trauma, anxiety, anger, depression, suicidal urges, addiction

Gender 33 Men 49 Women

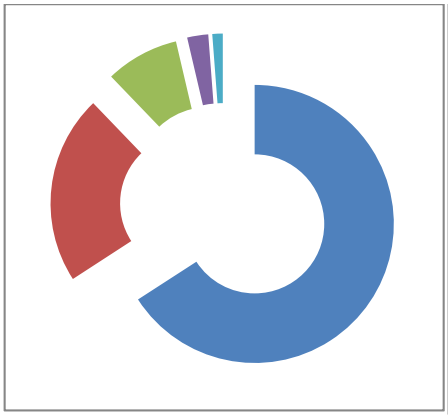




Ethnicity

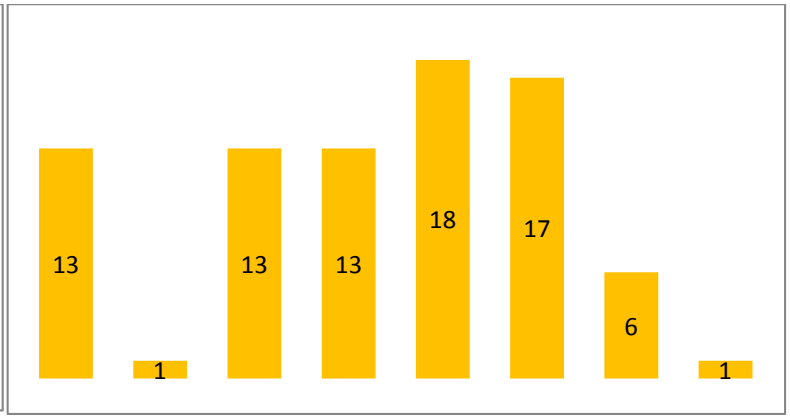
American Indian
Afghani
Vietnamese
Chinese
Hispanic
Declined to State
African American
Caucasian

Sexual Orientation



54 Heterosexual Clients
18 Declined to state
7 Gay Clients
2 Bisexual Clients
1 Pansexual Client

Age



(16)

Grief Counseling Outcomes

Grief counselors recognize and directly addresses client coping skill and specifically screen for depression, anxiety, panic, anger and suicidal ideation. Dr. David Burns Brief Mood Survey is administered at their initial session to establish a base line assessment, every ten sessions thereafter and at their final grief counseling session. Scores for depression, anxiety, anger, panic and suicidal urges are recorded and compared over the course of treatment. Clients are informed that the information gathered will be held in the strictest confidence and may only be used:

- To aid in developing a treatment plan for the client
- To compile statistical data of counseling outcomes
- To modify counseling program as needed to better serve clients

The criteria for utilizing survey outcomes are as follows:

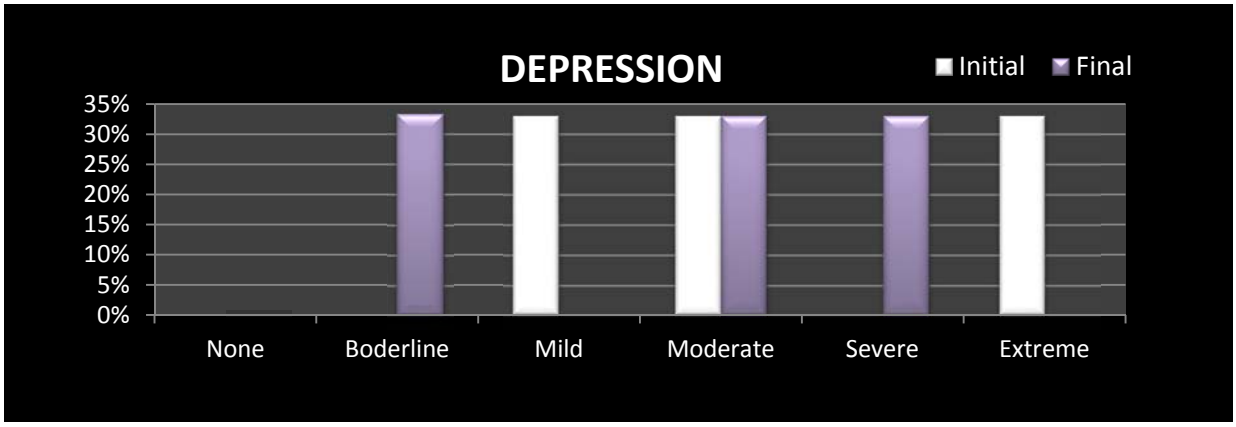
- Client agreed to take mood surveys at initial and final session
- Client received 20 grief counseling sessions
- Data collected was complete, signed and dated appropriately

The Dr. David Burns Brief Mood Survey is a series of 22 questions. Five questions each for depression, anxiety, panic and anger and two questions regarding suicidal urges.

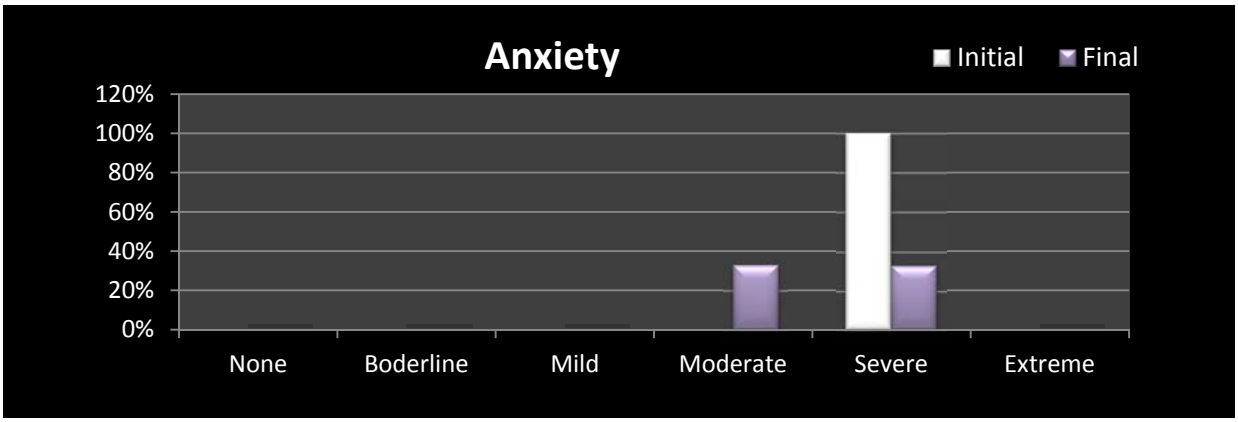
Clients answer the questions presented by the therapist by referring to an answer sheet which list: **0**-Not At All; **1**-Somewhat; **2**-Moderately; **3**-A Lot; **4**-Extremely. Grief counselors record client answers directly onto the survey and add the values to reach a final score for each section. Surveys become part of the client record and are compared over time.

Inquiring directly in this way, not just about depression but all their concerns, informs the client, in the very first session, that the challenges they are struggling with are important to talk about and that their feelings matter. Most clients experience a sense of relief and a glimmer of hope. Finally to be able to speak openly and confide in their counselor brings enormous comfort.

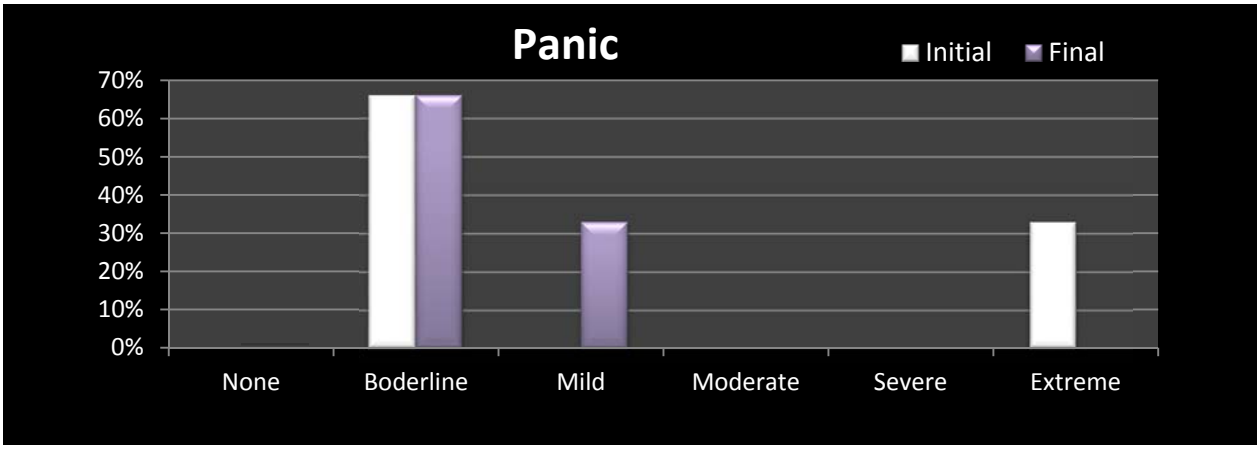
The five survey questions related to depression inquire about loss of pleasure or satisfaction in life. Clients are asked “in the last week including today” if they feel sad or down in the dumps, if they feel discouraged or hopeless and if they feel worthless and/or inadequate. The graph below shows the decrease in depression by comparing initial survey scores noted at their first grief counseling session with the scores noted at their final grief counseling session.



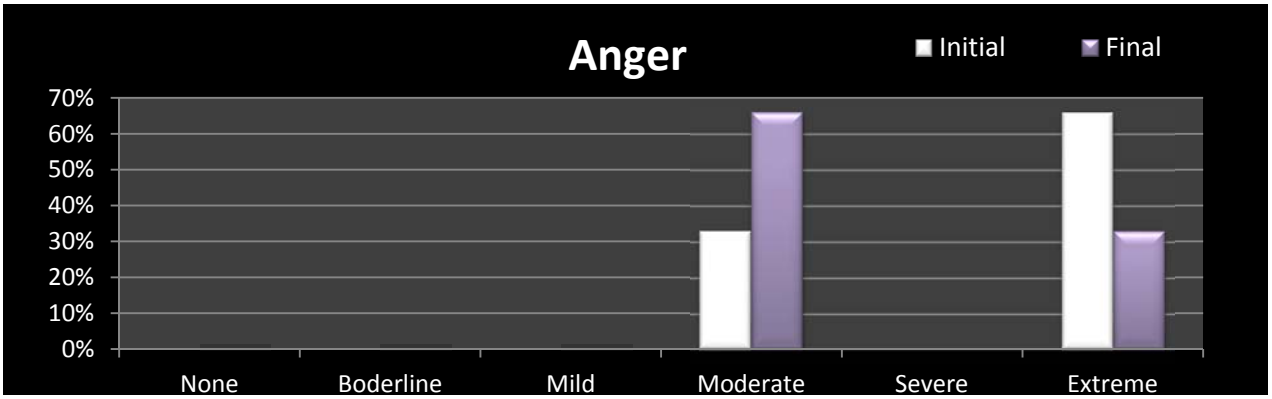
The five questions related to anxiety to ask “in the last week including today” if the client worries about things over and over, if they feel frightened, nervous, tense or on edge and if they feel anxious.



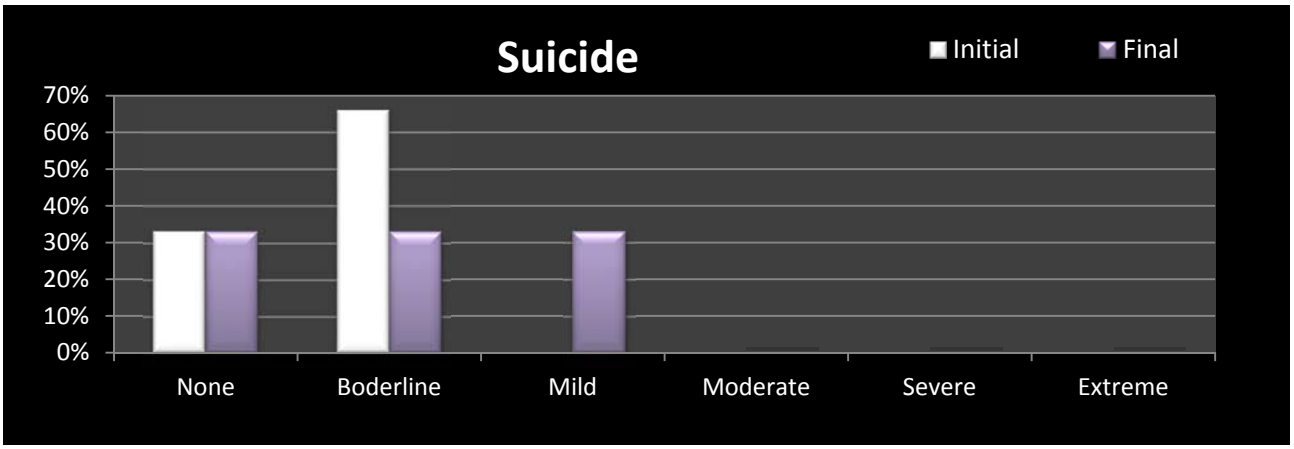
The five Questions related to panic ask “in the last week including today” about having sudden feelings of terror or overwhelming fear, sudden terrifying panic attacks that come out of the blue, suddenly feeling like you are going crazy or cracking up, or feeling like you are about to suffocate or pass out, suddenly feeling you’ll have a stroke, heart attack or die.



The five questions related to anger ask “in the last week including today” about feelings of frustration, annoyance, resentfulness, anger and irritation.



The two questions related to assessing for Suicidal Urges inquire directly “in the last week including today” about suicidal thoughts and the desire to end your life.



CSS provided three separate Survivor of Suicide Support Groups which each met weekly for 10 weeks. 19 adults ranging in age from 18 to 78 years of age participated.

City of Origin of Group Members			
Oakland	11	Castro Valley	1
Berkeley	3	San Pablo	1
San Francisco	2	Union City	1

City of Origin of Individual Grief Clients					
Oakland	31	Albany	2	El Cerrito	1
Berkeley	11	San Leandro	2	Pleasanton	1
Hayward	7	Emeryville	1	Livermore	1
Castro Valley	4	Alameda	1	Newark	1

(19)

Individual Grief Client Satisfaction Survey

At their last counseling session, grief counseling clients were presented with a stamped CSS addressed envelope, a Client Satisfaction Survey and an invitation to complete the survey at home and send it back to CSS via snail mail. Some clients opted to fill out the surveys in their last session.

For each statement, clients were asked to put an X in the circle that best represents his or her experience with their grief counseling experience. Surveys were returned by post or completed and given to their counselor at the last session.

The table below shows the answers indicated by grief clients to the items 1 – 11. The narrative to the right is a summary of suggestions and comments responders wrote to answer this open ended question: Please write in any suggestions on how we might improve? The results of the survey follow.

1. Was the intake process (initial telephone contact, returning your phone calls, scheduling your first appointment, and so on) satisfactory to you?

Definitely No	Mostly No	Neutral	Mostly Yes	Definitely Yes
08.3%	0%	0%	33.3%	58.3%

Question 1: The long wait from referral to first appointment was anxiety producing; then, the first appointment was disappointing because so much of the session was taken up with paperwork.

2. At your first appointment, was your counselor caring and respectful?

Definitely No	Mostly No	Neutral	Mostly Yes	Definitely Yes
0%	0%	0%	0%	100%

Question 2: Respondents commented that the counselors were compassionate, sensitive, supportive and insightful

3. Do you feel your counselor understood why you came for counseling?

Definitely No	Mostly No	Neutral	Mostly Yes	Definitely Yes
0%	0%	0%	25%	75%

(20)

4. Do you feel safe and clear about confidentiality issues in your counseling?

Definitely No	Mostly No	Neutral	Mostly Yes	Definitely Yes
0%	0%	0%	8%	92%

5. Did your counselor act professionally (arrive on time, promptly return messages, and so on)?

Definitely No	Mostly No	Neutral	Mostly Yes	Definitely Yes
0%	0%	0%	0%	100%

6. Were your counselor sensitive about and responsive to your culture and ethnicity?

Definitely No	Mostly No	Neutral	Mostly Yes	Definitely Yes
0%	0%	0%	0%	100%

7. Did your counselor help you clarify and work toward a goal or goals in your counseling?

Definitely No	Mostly No	Neutral	Mostly Yes	Definitely Yes
0%	0%	0%	25%	75%

8. Did you feel you accomplished what you wanted to in counseling?

Definitely No	Mostly No	Neutral	Mostly Yes	Definitely Yes
0%	0%	0%	33%	67%

Question 8: One respondent commented, "I'm very satisfy with all phases of recovery".

(21)

9. Overall, were you satisfied with your grief counseling experience?

Definitely No	Mostly No	Neutral	Mostly Yes	Definitely Yes
0%	0%	0%	17%	83%

Question 9: One respondent suggested a bigger facility would be an improvement.

10. If you never used the telephone crisis line, please check here ☐ and skip this question. If you used the crisis line, did you find it helpful?

Definitely No	Mostly No	Neutral	Mostly Yes	Definitely Yes
20%	20%	0%	0%	60%

Question 10: None of these responders made any comments about their experience or suggestions for improvement.

11. Would you refer others to crisis Support Services for counseling?

Definitely No	Mostly No	Neutral	Mostly Yes	Definitely Yes
0%	0%	0%	0%	100%

Group Grief Counseling Satisfaction Survey

1. Was the intake process (initial telephone contact, returning your phone calls, scheduling your first appointment, and so on) satisfactory to you?

Definitely No	Mostly No	Neutral	Mostly Yes	Definitely Yes
0%	0%	0%	16%	83%

Question 1: the group was heavy on readings, resources and psychoeducation. This individual indicated that they appreciated more the time counselors spent drawing out feelings, "listening to grief" and "solicitation and witnessing".

2. At your first group meeting, were your counselor (s) caring and respectful?

Definitely No	Mostly No	Neutral	Mostly Yes	Definitely Yes
0%	0%	0%	0%	100%

(22)

3. Did you feel your counselor (s) help you form a realistic view of what you could expect from counseling?

Definitely No	Mostly No	Neutral	Mostly Yes	Definitely Yes
0%	0%	0%	17%	83%

4. Did you feel safe and clear about confidentiality issues in your counseling?

Definitely No	Mostly No	Neutral	Mostly Yes	Definitely Yes
0%	0%	0%	0%	100%

5. Did your counselor (s) act professionally (arrive on time, promptly return messages, and so on)?

Definitely No	Mostly No	Neutral	Mostly Yes	Definitely Yes
0%	0%	0%	0%	100%

6. Were your counselor (s) sensitive about and responsive to your issues of diversity and culture?

Definitely No	Mostly No	Neutral	Mostly Yes	Definitely Yes
0%	0%	17%	0%	83%

7. Did your counselor (s) help you clarify and work toward a goal or goals in your counseling?

Definitely No	Mostly No	Neutral	Mostly Yes	Definitely Yes
0%	0%	0%	40%	60%

8. Did you feel you accomplished what you wanted with your group counseling?

Definitely No	Mostly No	Neutral	Mostly Yes	Definitely Yes
0%	0%	17%	33%	50%

It was also noted that a group at this time of day and of this length is difficult for older people in the winter months because of the time change.

10. If you never used the telephone crisis line, please check here ☐ and skip this question. If you used the crisis line, did you find it helpful?

Definitely No	Mostly No	Neutral	Mostly Yes	Definitely Yes
0%	20%	0%	0%	80%

11. If you never received individual counseling at Crisis Support, check here ☐ and skip this question. If you did, did you find it helpful?

Definitely No	Mostly No	Neutral	Mostly Yes	Definitely Yes

12. Would you refer others to crisis Support Services for counseling?

Definitely No	Mostly No	Neutral	Mostly Yes	Definitely Yes
0%	0%	0%	0%	100%

9. Overall, were you satisfied with your group counseling experience?

Definitely No	Mostly No	Neutral	Mostly Yes	Definitely Yes
0%	0%	0%	33%	67%

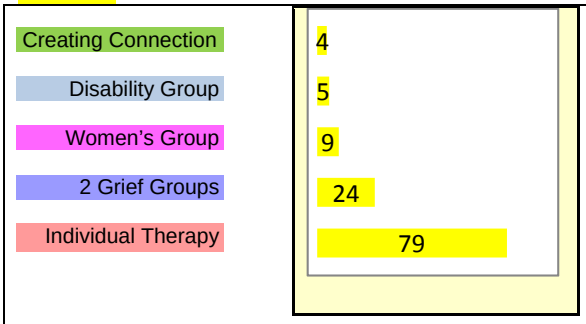
Interns provided 335 individual grief sessions, 122 group grief sessions and 578 logistical and/or supportive telephone calls to grief clients.

The tasks of mourning are multifold, complicated and definitely not linear. This is especially true when the death is the result of suicide, homicide or a sudden traumatic event. Yet death is an intrinsically intertwined component of life since the beginning of time. And still, each one of feels that the world must stand still with the death of a loved one. For, no matter how many billions have died before, the intrinsic value of this particular loved one is not diminished.

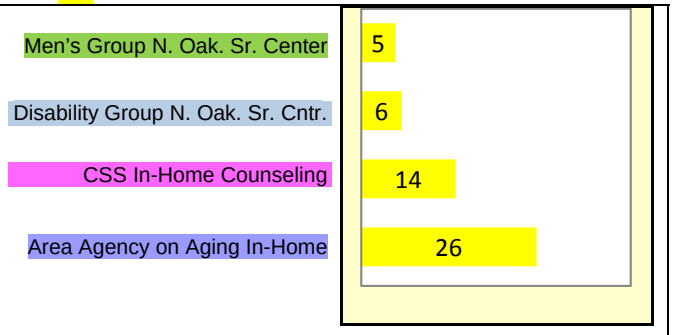
We eventually accept the reality of the loss, work through the pain, adjust to a world without the deceased and emotionally move forward with life.

Counseling for Older Adults 172 Clients

121 Older Adult On-Site Clients



51 Older Adult Off-Site Clients



On-Site Top Areas of Concern
grief, anxiety, social skills, aggression, alone
disability, transportation, health, anxiety
divorce, depression, trauma, poverty, anxiety
grief, depression, suicidal urges, anxiety
trauma, poverty, dpression, divorce, grief, anxiety, suicidal urges, care giving, chronic mental illness, isolation, health, drug/alcohol

Off-Site Top Areas of Concern
health, divorce, depression, family discord, grief
disability, transportation, health, anxiety
isolation, disability, depression, divorce, grief, trauma
poverty, isolation, health, grief, suicidal urges, anxiety, family discord, trauma, depression

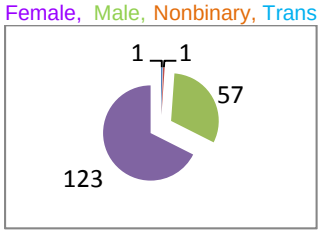
Total Number of Sessions and Calls	
1345	1309

Total Number of Sessions and Calls	
942	558

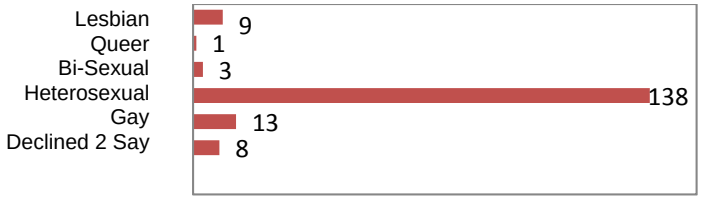
City of Origin of On-Site Clients			
Oakland	59	Berkeley	26
San Leandro	7	Alameda	8
El Cerrito	2	Hayward	3
Union City	1	Richmond	1
Emeryville	3	San Pablo	1
Kensington	1	Pleasanton	1
Fremont	1	Piedmont	1
El Sobronte	1	Castro Valley	2
Orinda	1	Albany	2

City of Origin of Off-Site Clients					
N. Oak. Sr, Cntr.		Agency on Aging		CSS	
Oakland	9	Oakland	6	Oakland	9
Berkeley	1	San Leandro	5	Berkeley	3
Emeryville	1	Berkeley	4	Albany	1
		San Lorenzo	4	Hayward	1
		Hayward	3		
		Castro Valley	3		
		Albany	1		

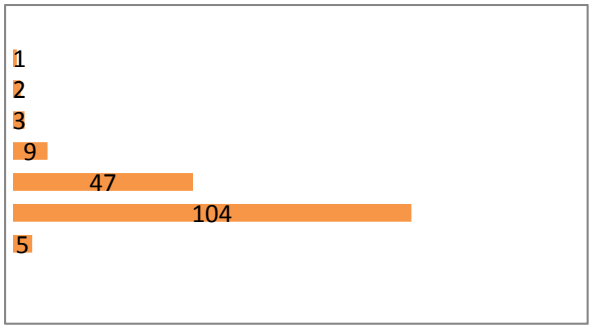
Gender



Sexual Orientation

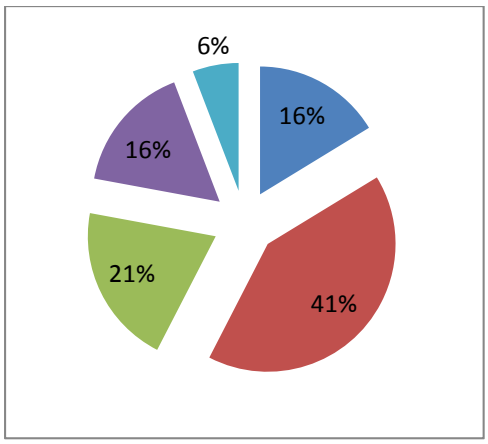


Ethnicity



Japanese Client
American Indian Clients
Chinese Clients
Hispanic Clients
African American Clients
Caucasian Clients
Clients Decline to State

Age



55-58 years old 28 Clients

59-68 years old 71 Clients

69-78 years old 35 Clients

79-88 years old 28 Clients

88+ years old 10 Clients

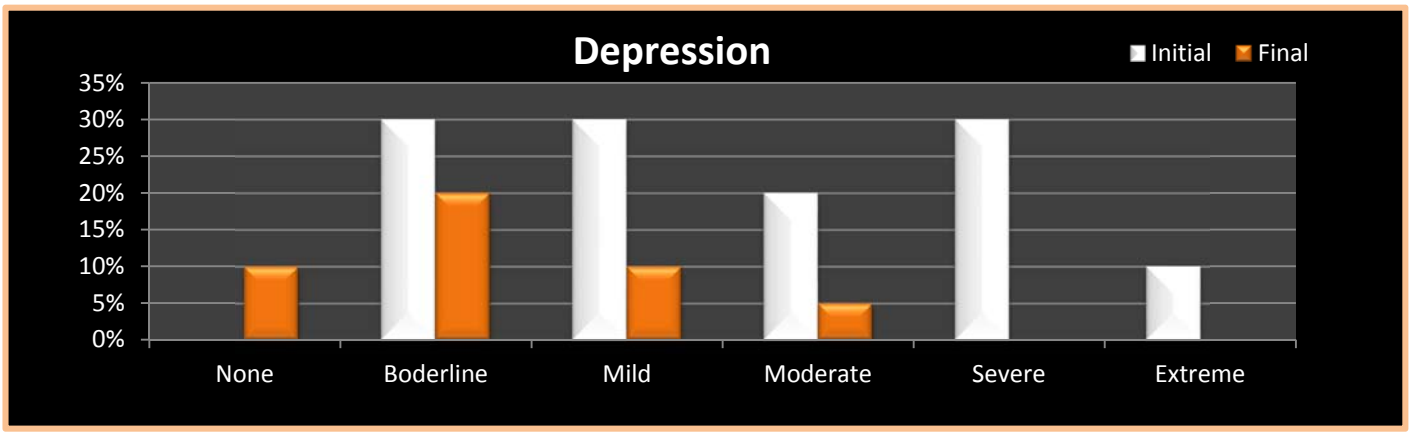
Older adult services offer unlimited individual and group counseling. Off-site counseling is free to all in-home and group counseling clients although we do request a donation. Clients do not have to give a donation to receive services. On-site clients are charged on a sliding scale and no one is turned away because of inability to pay.

Older Adults are also invited to utilize Dr. Duncan's Outcome and Session Rating Scales each week. Not all clients find these instruments helpful. When this is the case, it becomes second nature for interns to weave all or part of these surveys into their time with clients informally.

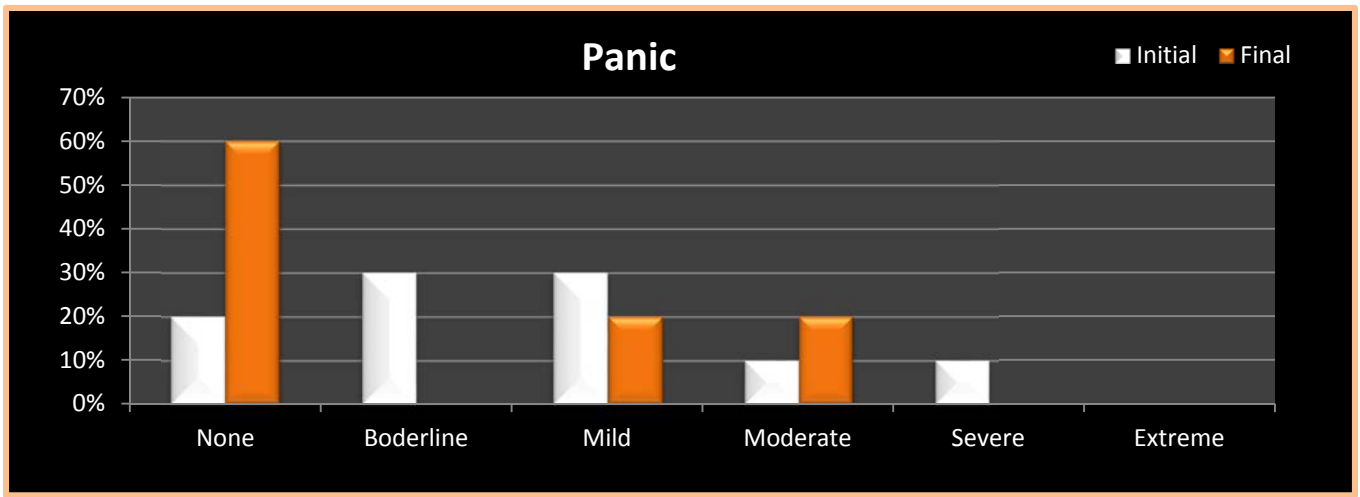
Dr. David Burns Mood Survey is also used with older clients and again, not all older adults fine the instrument useful. When counselors ask in conversation with open ended questions, clients readily unburden themselves. Additions questions which screen for trauma, cognitive functioning, alcohol and drug use, abuse and tasks of daily functioning are standard.

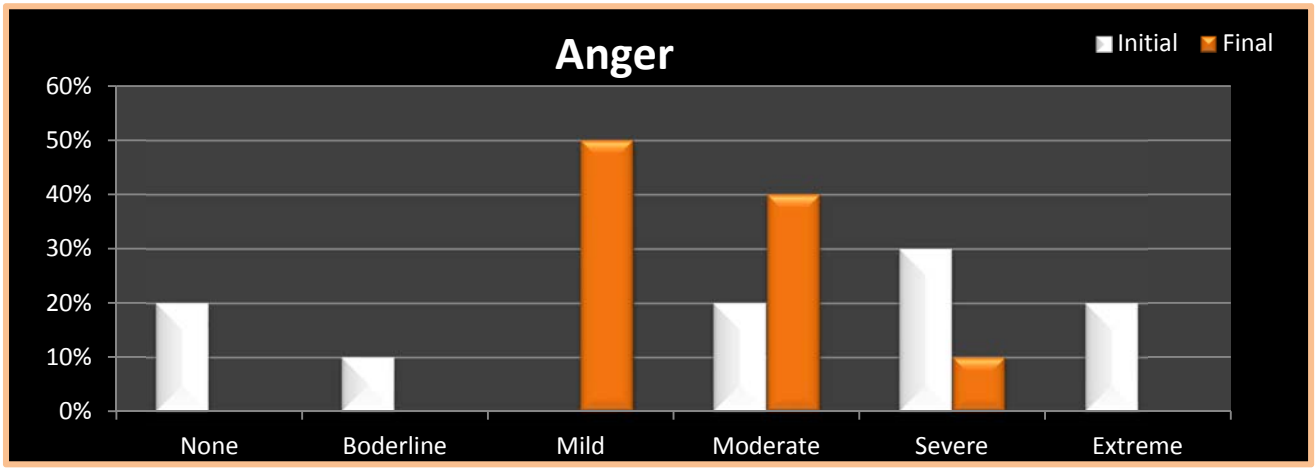
(26)

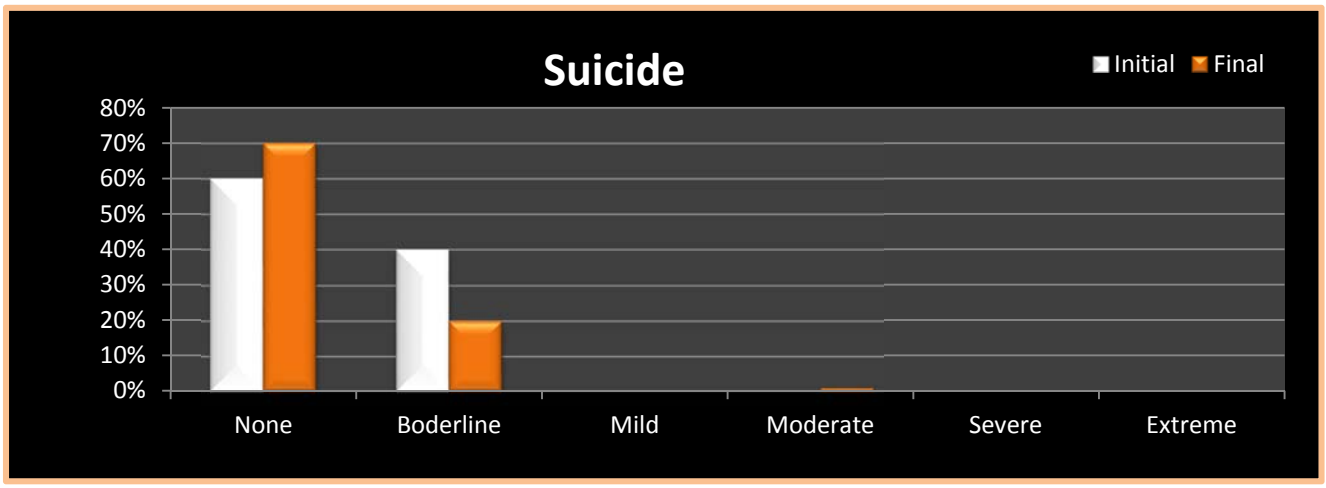
Older Adult Counseling Mood Survey Outcomes



.







On-Site Older Adult Client Satisfaction Survey

1. Was the intake process (initial telephone contact, returning your phone calls, scheduling your first appointment, and so on) satisfactory to you?				
Definitely No	Mostly No	Neutral	Mostly Yes	Definitely Yes
0%	7.1%	14.2%	14.2%	64.2%

Question 1. Clients who were mostly dissatisfied with or neutral about the intake process commented about the long wait for assignment of a counselor.

2. At your first appointment, was your counselor caring and respectful?

Definitely No	Mostly No	Neutral	Mostly Yes	Definitely Yes
7%	0%	0%	14%	79%

3. Did your counselor help you form a realistic view of what you could expect from counseling?

Definitely No	Mostly No	Neutral	Mostly Yes	Definitely Yes
0%	7.1%	0%	35.7%	57.1%

4. Did you feel safe and clear about confidentiality issues in your counseling?

Definitely No	Mostly No	Neutral	Mostly Yes	Definitely Yes
0%	0%	7.1%	7.1%	85.7%

5. Did your counselor act professionally (arrive on time, promptly return messages, and so on)?

Definitely No	Mostly No	Neutral	Mostly Yes	Definitely Yes
7%	0%	0%	14%	79%

6. Was your counselor sensitive about and responsive to issues of diversity and culture

Definitely No	Mostly No	Neutral	Mostly Yes	Definitely Yes
0%	0%	7%	7%	86%

7. Did your counselor help you clarify and work toward a goal or goals in your counseling?

Definitely No	Mostly No	Neutral	Mostly Yes	Definitely Yes
0%	7.1%	0%	28.6%	64.3%

Question 2. A client who was definitely dissatisfied with the first appointment commented that her counselor didn't show up for the 1st appointment and that they didn't leave a message anywhere; then, the counselor was late for the 2nd appointment. Client was displeased with the counselor's demeanor and skill level.

When asked for suggestions on how to improve services, most made no comment or commented that nothing needs to be changed. For example, "No. I think the county of Alameda crisis support services do a good job @ dealing & coping with clients in the county! Regardless of the population the(y) might be in. senior children etc.!!!", and "None – Susanne is a Gem and has been very help full to my self and family."

8. Did you feel you accomplished what you wanted to in counseling?

Definitely No	Mostly No	Neutral	Mostly Yes	Definitely Yes
0%	7.1%	0%	42.8%	50%

9. Overall, were you satisfied with your senior counseling services?

Definitely No	Mostly No	Neutral	Mostly Yes	Definitely Yes
0%	0%	0%	21%	79%

Other suggestions for our improvement included that we pay more careful attention to the selection of interns and the assignment to assure a satisfactory fit vis-à-vis age and maturity level and that counselors should be more familiar with end of life planning and community resources.
While on the other hand, this client contextualized her feedback by stating that she had "exceptional" counselors with our agency in the past.

Another client commented that the service was, "too short".

10. If you never used the telephone crisis line, please check here ☐ and skip this question. If you used the crisis line, did you find it helpful?

Definitely No	Mostly No	Neutral	Mostly Yes	Definitely Yes
20%	20%	0%	20%	40%

11. Would you refer a friend to the Senior Counseling Program at Crisis Support Services?

Definitely No	Mostly No	Neutral	Mostly Yes	Definitely Yes
0%	0%	7%	21%	71%

Question 10. When asked about the Crisis Line 5 responders had used the crisis line and the scores at the left represent their satisfaction with these services.
A client who was definitely dissatisfied with the crisis line stated, "the woman said I was "keeping her from her brunch"".
Question 11. Clients said they were referred by senior centers, the Alameda One-Stop Career Center, one by a friend and another by the National Multiple Sclerosis Society.

(30)

In-Home Older Adult Client Satisfaction Survey

1. My counselor always arrived when expected.

Always	Most of the Time	Some of the time	Occasionally	Never
75%	25%	0%	0%	0%

2. My counselor was easy to talk to.

Always	Most of the Time	Some of the time	Occasionally	Never
100%	0%	0%	0%	0%

3. My counselor was respectful and acted as I expected in my home.

Always	Most of the Time	Some of the time	Occasionally	Never
100%	0%	0%	0%	0%

4. I trust my counselor to keep things we talked about confidential.

Always	Most of the Time	Some of the time	Occasionally	Never
94%	6%	0%	0%	0%

5. I looked forward to appointments with my counselor.

Always	Most of the Time	Some of the time	Occasionally	Never
73%	20%	7%	0%	0%

Item 6 asks: **If you have had more than one counselor, how was the change from one to another for you?** 46% were positive, 23% were neutral and 30% were negative.

Item 7 asks: **What has been most helpful to you about the Senior Program?** 99% of these responses were positive. Most comments reflected on the fulfillment of the need to have someone to talk to, the consistency of the support and the convenience of having the counselor come to their home.

Item 8 asks: **What would make our service better?** 64% of the responses centered on the desire for more or longer sessions or the desire to continue with one counselor.

(31)

Older Adult Group Counseling Client Satisfaction Survey

1. Was the intake process (initial telephone contact, returning your phone calls, scheduling your first appointment, and so on) satisfactory to you?

Definitely No	Mostly No	Neutral	Mostly Yes	Definitely Yes
0%	0%	0%	43%	57%

2. At your first group meeting, were your counselor(s) caring and respectful?

Definitely No	Mostly No	Neutral	Mostly Yes	Definitely Yes
0%	0%	0%	14%	86%

3. Did your counselor (s) help you form a realistic view of what you could expect from counseling?

Definitely No	Mostly No	Neutral	Mostly Yes	Definitely Yes
0%	14.3%	0%	14.3%	71.4%

4. Did you feel safe and clear about confidentiality issues in your group?

Definitely No	Mostly No	Neutral	Mostly Yes	Definitely Yes
0%	0%	0%	0%	100%

5. Did your counselor(s) act professionally (arrive on time, promptly return messages, and so on)?

Definitely No	Mostly No	Neutral	Mostly Yes	Definitely Yes
0%	0%	0%	33%	67%

The scores at left reflect 7 groups combining on-site and off-site results.

One group didn't fare too well due to lack of membership and intermittent participation by the members.

One responder felt that there was not a serious effort to bring new members into the group.

Another responder commented that the facilitators could use some training around working with interpersonal conflict between group members.

This individual didn't feel comfortable bringing their concerns to the group and repeatedly wanted a private consult with a co-facilitator.

(32)

6. Were your counselors sensitive about and responsive to issues of diversity and culture

Definitely No	Mostly No	Neutral	Mostly Yes	Definitely Yes
0%	0%	0%	17%	83%

7. Did your counselor(s) help you clarify and work toward a goal or goals in your counseling?

Definitely No	Mostly No	Neutral	Mostly Yes	Definitely Yes
0%	0%	40%	20%	40%

8. Did you feel you accomplished what you wanted to in group counseling?

Definitely No	Mostly No	Neutral	Mostly Yes	Definitely Yes
0%	0%	17%	17%	66%

9. Overall, were you satisfied with your group counseling experience?

Definitely No	Mostly No	Neutral	Mostly Yes	Definitely Yes
0%	0%	0%	14%	86%

10. If you never used the telephone crisis line, please check here ☐ and skip this question. If you used the crisis line, did you find it helpful?

Definitely No	Mostly No	Neutral	Mostly Yes	Definitely Yes
0%	0%	33.3%	33.3%	33.3%

11. If you never received individual counseling at Crisis Support check here ☐ and skip this question. If you used the crisis line, did you find it helpful?

Definitely No	Mostly No	Neutral	Mostly Yes	Definitely Yes
0%	0%	0%	100%	0%

In spite of the difficulties, most responders had additional comments that were positive. Overall, people were satisfied with their experience and would recommend Crisis Support to others.

(33)

12. Would you refer others to crisis Support Services for counseling?

Definitely No	Mostly No	Neutral	Mostly Yes	Definitely Yes
0%	0%	14%	0%	86%

Survey responses from clients always provide valuable information which we utilize to inform and reshape services to better respond and reflect client need and the clients themselves. In the case of older adults, recruitment of older interns is essential.

Some challenges are more difficult to address. The request for services always exceeds our capacity to serve. In August the waiting list really begins to builds with interns finishing up with CSS and new interns not ready to take clients until September.

We have questioned the service model of unlimited session to see if the model was created a log jam of clients that continued counseling beyond their need.

The attachment that develops between a client and intern is strong and contributes greatly to the positive outcomes across all programs. Interns move on from their CSS placement and the timing is not always optimal. Interns address separation and abandonment with clients but occasionally the sadness, grief and anger in response to the loss of a valued relationship spills over onto the new intern especially if the client has a history of unresolved grief and abandonment. New intern are aware of the challenges of being the “new” intern and beginnings may be rocky.

Clients will frequently express their gratitude directly to their counselor. Occasionally, I will receive a call or a card from a client who makes that extra effort to let me and CSS know how positively impactful our counseling services have been for them.

I got a call from a long term African American client in her 80’s who first came to us for grief counseling when her husband died. For the past 3 years she has been caring for her adult son with kidney failure. Her voicemail message was generous in gratitude and appreciation. She wanted to let me know that her counselor is making a difference in her ability to cope and manage her anxiety.

Another client, I would like to mention is from the Philippines, now a resident of Oakland and very far from family. She came for counseling soon after she learned from her doctor that she needed a very complicated surgery which required a long road of physical therapy and patience. Now that she is back on her feet, she sent a card reflecting on the invaluable support she received from her CSS counseling through her anticipation of the surgery, the surgery, rehabilitation and now recovery.

Both of these clients receive in-home counseling due to their inability to drive, lack of social support, low income. Until their experience of receiving CSS counseling, they had an almost insurmountable wall of stigma about mental health care. They both represent our ideal senior client who otherwise would not avail themselves to mental health treatment but who would benefit greatly from it.

Our commitment to older adults is based on assessment, client need and client treatment goals. Research has indicated that the number one debilitating issue seniors face is loneliness. This issue of social isolation coupled with depression and the stigma of mental health treatment are important factors contributing to the high risk for suicide among older adults.

Older adults with depression rarely seek treatment for the illness and may mistake the symptoms of depression as signs of dementia. Unrecognized and untreated depression has fatal consequences in terms of both suicide and non-suicide mortality. Depression is the single most significant risk factor for suicide in older adults. Seniors typically describe depression as physical symptoms and doctors treating seniors are often general practitioners not trained as geriatric specialist. Medical care providers are more aware and we receive referrals from Kaiser, Life Long Medical, Horizon Health and Blue Cross to mention a few.

Alameda County has taken a proactive stance in an effort of sustaining and expanding services to older adults, LGBTQI2 residents and youth. Efforts to improve services, understand the need and ensure that the most needy, vulnerable and at-risk are being served.

Crisis Support Services, as a partner of Alameda County Behavioral Health, is dedicated to providing trauma informed, culturally sensitive, evidence based crisis intervention and prevention services to all who find their way to CSS.

Devah DeFusco
CSS Clinical Director
510-420-2475
Crisissupport.org

Marjorie Darrow
CSS Clinical Program Coordinator
510-420-2485
Crisissupport.org

CRISIS SUPPORT SERVICES
of Alameda County

Community Education Program

Year End Report 2014-2015

The 2012 National Strategy of Suicide Prevention (NSSP), states that the first goal of suicide prevention is to promote awareness that *suicide is a public health issue.* It supports the message that we all have a role in preventing suicide and spreading the message of hope. Better awareness that suicide is a serious public health problem results in knowledge change, which then influences beliefs and behaviors. Among NSSP's primary aims are to promote opportunities and settings to enhance *connectedness* among persons, families, and communities.

Connectedness is a common thread that weaves together many of the influences of suicidal behavior and has direct relevance for prevention, which is among the protective factors for suicidality. The Center for Disease Control (CDC) defines connectedness as the degree to which a person or group is socially close, interrelated, or shares resources with other persons or groups.

Crisis Support Services of Alameda County (CSS) has provided suicide prevention and intervention services in Alameda County for almost 50 years. While no single intervention can prevent all suicides, according to the Suicide Prevention Resouce Center and Jed Foundation, research has shown that a comprehensive approach is most effective. A comprehensive approach to suicide includes seven key strategies (image below) most of which are utilized and supported by our agency in some capacity.

Community education enhances our agency's capacity to fulfill the goals of this approach, by training our community to identify people at risk, increase help-seeking among those who are in crisis, connecting those who are vulnerable to our mental health counseling and crisis management services, and responding to a crisis in the community by providing postvention services.

Our Community Education Program serves as one of the many linkages between our agency and those in the community who are in a position of helping to foster *connectedness and hope.*

Our Community Education Program adheres closely to the following goals and objectives of NSSP's national strategic effort for suicide prevention on a local level:

Goal 2. Implement research-informed communication efforts designed to prevent suicide by changing knowledge, attitudes, and behaviors.

Objective 2.4: Increase knowledge of the warning signs for suicide and of how to connect individuals in crisis with assistance and care.

Goal 3: Increase knowledge of the factors that offer protection from suicidal behaviors and that promote wellness and recovery

Objective 3.2: Reduce the prejudice and discrimination associated with suicidal behaviors and mental and substance use disorders.

Objective 3.3: Promote the understanding that recovery from mental and substance use disorders is real and possible for all.

Goal 7: Provide training to community and clinical service providers on the prevention of suicide and related behaviors

Objective 7.1 Provide Training on suicide prevention to community groups that have a role in the prevention of suicide and related behaviors

Objective 7.2: Provide training to mental health and substance abuse providers on the recognition, assessment, and management of at-risk behavior, and the delivery of effective clinical care for people with suicide risk.

Crisis Support Services of Alameda County is pleased to submit a Year End Summary of our Community Education Program from July 2014 through June 2015 for services provided.

TEENS FOR LIFE PROGRAM (TFL): SCHOOL BASED SUICIDE PREVENTION

What do we know about youth suicide?

Suicide is the 2nd leading cause of death of those 10-24 years old in the United States *(Center for Disease Control, 2011)*

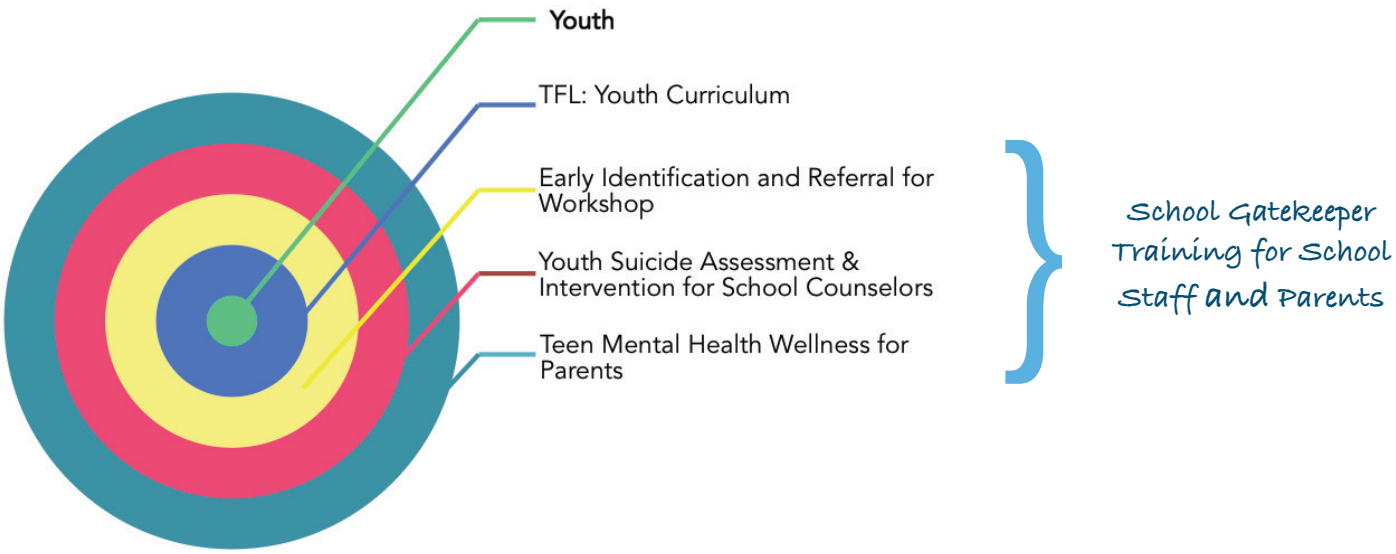
What else do we know?

Schools have the largest population of youth in one setting. A school community knowledgeable about suicide prevention begins with each and every individual who is part of that community.

Vital to a teen's mental health wellness is a strong and supportive network at home. While most young people are resilient and healthy, a family plays an important role in being aware of the signs and symptoms when their child may be experiencing mental health distress.

How do we address youth suicide?

Suicide prevention experts recommend using a multifaceted approach that addresses multiple layers of young person's environment. Our Teens for Life Program (TFL) aims to provide a **full circle of support** for the student who may be at risk for suicide (see image below).



Who are School Gatekeepers?

School Gatekeepers are natural helpers. The role of a gatekeeper should ultimately connect a link or open the "gate", between a young person and a school mental health professional.

Teens for Life: Youth Curriculum for Middle School & High School Youth

Our classroom-based youth suicide prevention workshops for middle school and high school youth enhances a young person's ability to identify a peer who may be in crisis and encourage them to find help for a friend. The workshop covers depression and suicidal warning signs and how to help. The curriculum encourages youth to **connect** a friend in trouble to a trusted adult and/or our 24-Hour Crisis Line and Teen TextLine.

Teens for Life: School Gatekeeper Training for School Staff

Early Identification and Referral for Teachers and other School Staff

The reluctance of youth to seek out helpful adults is considered to be a risk factor, however, research has shown that *contact* with helpful adults may be considered a protective factor for a variety of troubled youth (Prevention Division of the American Association of Suicidology, *Guidelines for School Based Suicide Prevention Programs*, 1999). Teachers play a role as natural helpers. Our training educates teachers on how to recognize suicidal warning signs, risk factors, how to ask about suicide directly, and when to connect a student to school mental health services.

Youth Suicide Assessment and Intervention for School Mental Health Counselors

In both our youth curriculum and teacher workshop, we encourage our youth and our teachers to connect a student to school mental health counselors. Our clinical training provides information on current best practices on suicide assessment and intervention tools.

Teens for Life: Teen Mental Health Wellness

Vital to a teen's mental health wellness is a strong and supportive network at home. While most young people are resilient and healthy, a family plays an important role in being aware of the early signs and symptoms when their child may be experiencing a mental health crisis that may place a child at suicidal risk.

7

Number of youth who approached a speaker after a presentation. Often, these connections are youth who are concerned about a friend who is feeling suicidal or a young person who is concerned about themselves and their own suicidality. These interactions allow our speakers the opportunity to engage and make sure that the youth is safe and connect them to resources within the school.

722

Number of Calls from those age 10-19 years old (self-reported) to our crisis line. During the school year that TFL is in schools there is a noted rise in calls from youth. Last school year, we received 321 calls from those under 19 years old.

5

Top Themes of calls from youth (age 10-19 years): #1 Suicide and Self-Injury #2 General Mental Health #3 Family Issues #4 Social Issues #5 Abuse/Violence

14 out 18

School Districts in Alameda County

9

Middle Schools

22

High Schools

306

Total classroom presentations

9,000

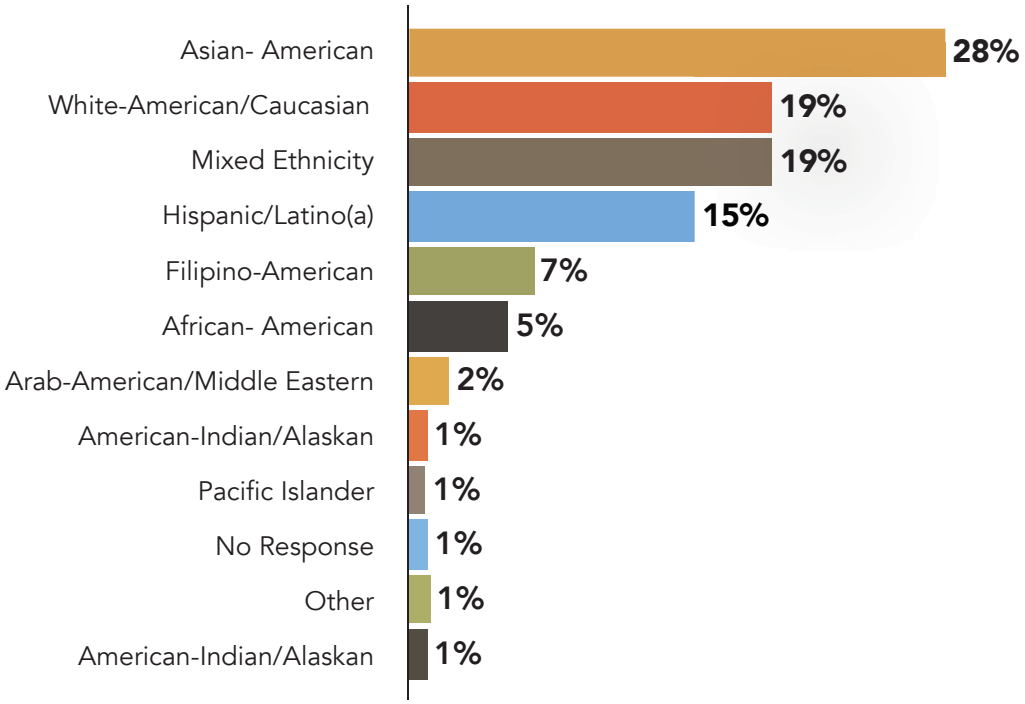
Total # of youth who received the TFL presentations (Goal 9,000)

Program Presence in Alameda County

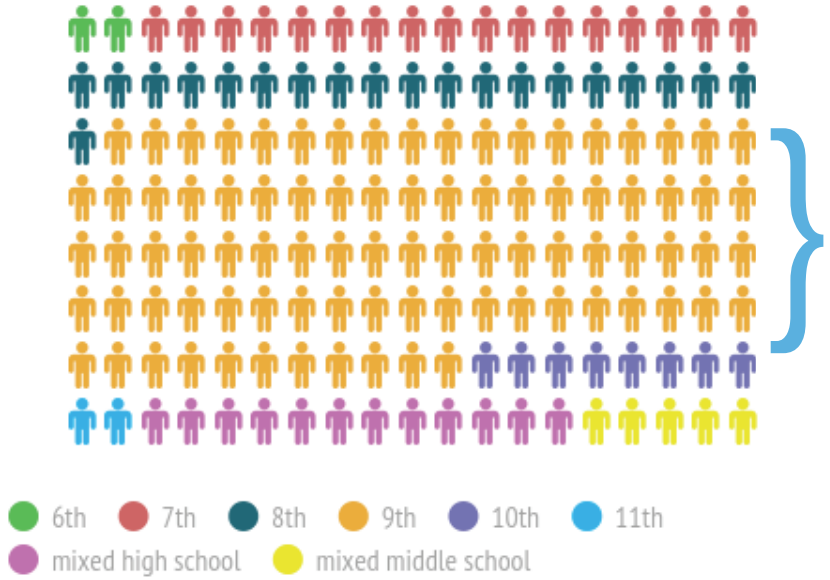
Unified School District	Middle School	High School
Albany USD		Albany HS
Alameda USD	Lincoln MS	Alameda HS Island HS
Berkeley USD	Longfellow MS Martin Luther King Jr. MS	St. Mary's College HS (private) Teens Tackle Tabacco Conference*
Castro Valley USD		Castro Valley HS
Dublin USD		Dublin HS
Fremont USD	Horner Jr. High Thorton Jr. High	Irvington HS Mission San Jose HS
Hayward USD	Cesar E. Chavez MS	Hayward HS
Livermore USD		Granada HS
Newark USD		Newark Memorial HS
New Haven USD	Alvarado MS	Decoto School for Independent Study James Logan HS
Oakland USD		BayHill HS Skyline HS Madison Park Academy Oakland Technical HS Holy Spirit School (private)
Piedmont USD		Piedmont HS
Pleasanton USD	Harvest Park MS	Foothill HS Village HS
San Lorenzo USD	Washington Manor MS	Arroyo HS

Self- Reported Demographics from 3, 596 Youth surveyed out 9,000 Total

ETHNICITY



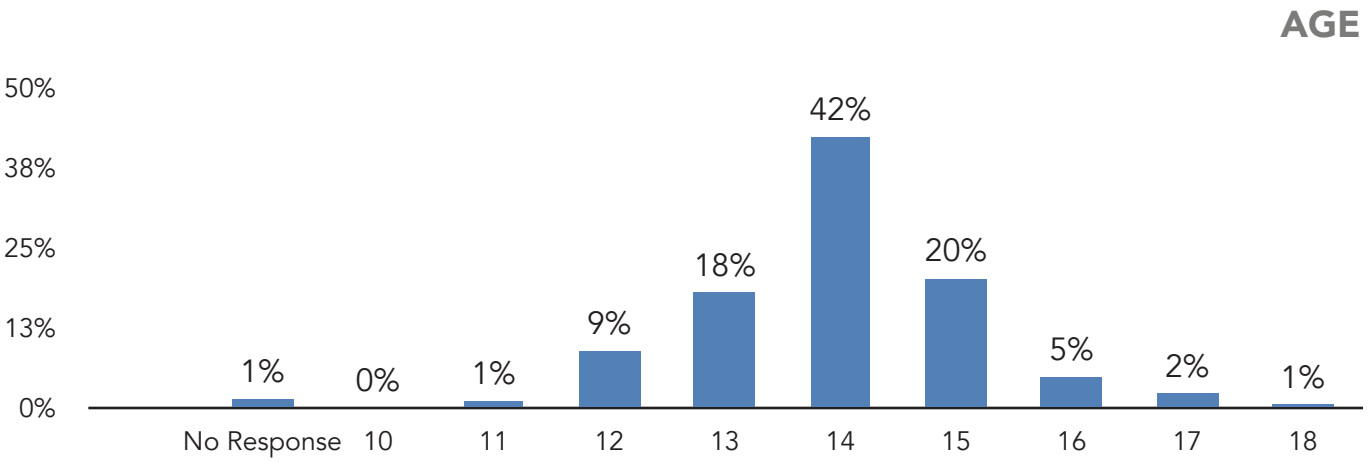
GRADE

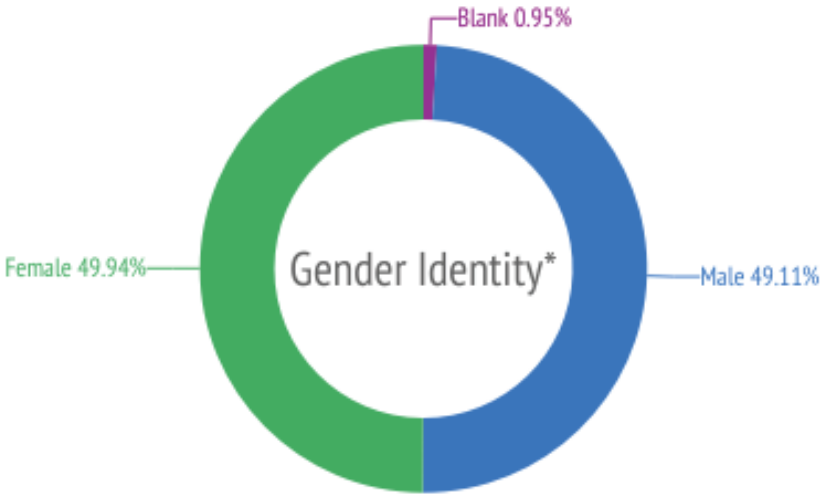


56% of youth in our program are in 9th grade.

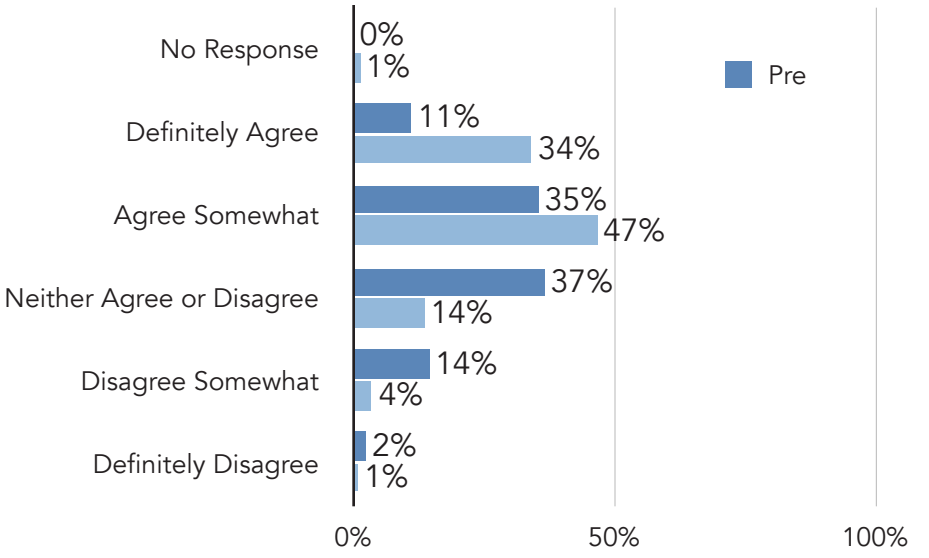
Create infographics infogr.am

Self- Reported Demographics from 3, 596 Youth surveyed out 9,000 youth total

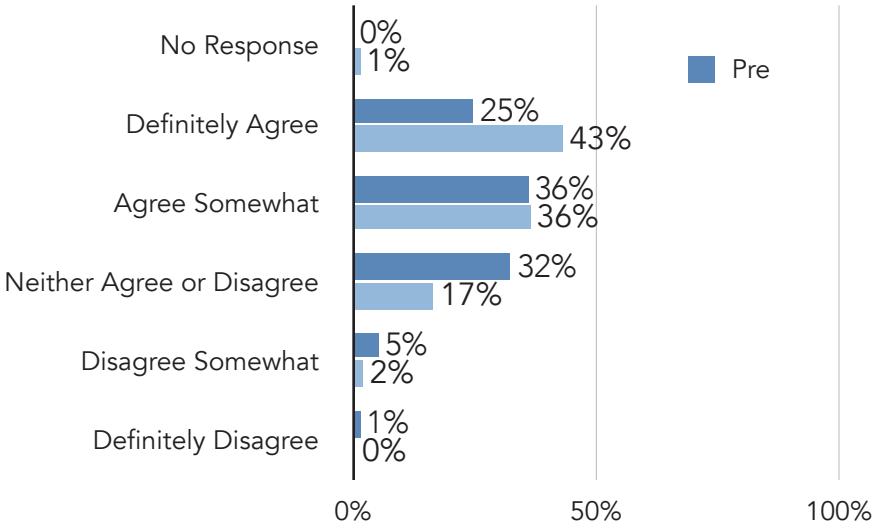




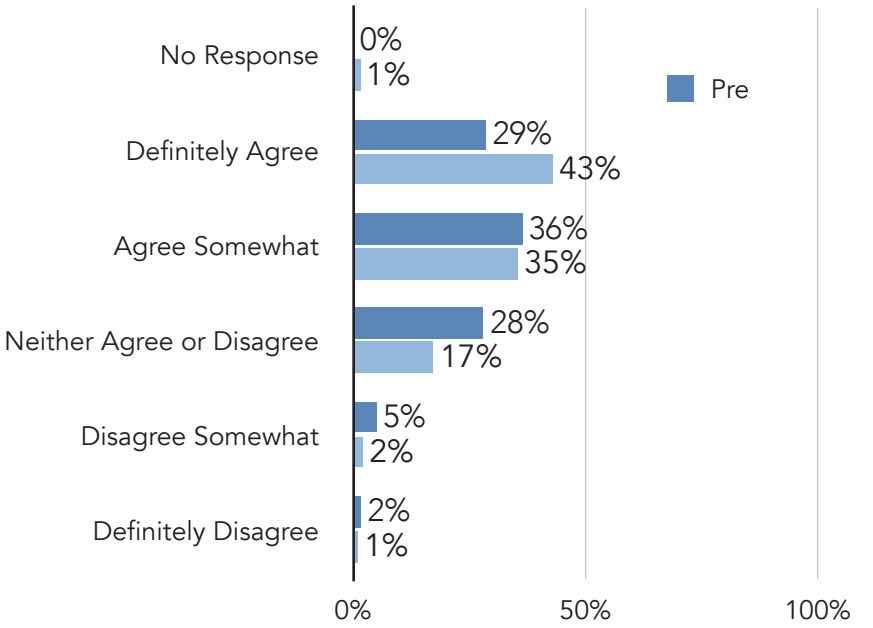
*Our current teen survey provided only Binary options for gender self-identity. One of the our goals this year is to determine how best to be more inclusive in gathering information on gender identity in the classroom.



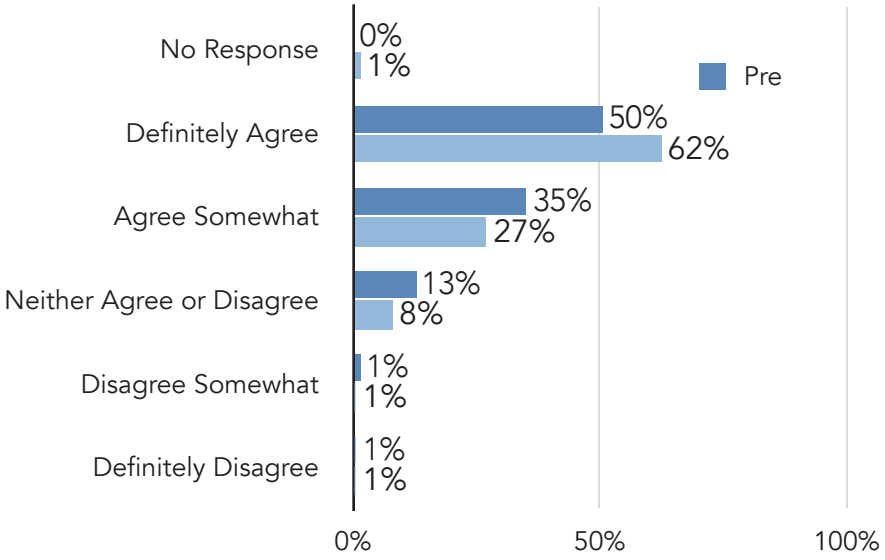
"I can recognize if someone close to me is feeling suicidal"



"If I had a friend who was feeling depressed or suicidal, I would be willing to call a crisis line."



"If I had a friend who was feeling depressed or suicidal, i would be willing to **text** a crisis line."



"I personally feel that receiving education about suicide is helpful to others"

**Our evaluation tool is composed of 9 content areas that address the 3 main goals of the Teens for Life Program: Youth Curriculum. These content areas allow us to measure whether our goals are being met. The above are highlights. Results of all content areas are available on request.*

Program by the Numbers

Who are School Gatekeepers?

School Gatekeepers are natural helpers. The role of a gatekeeper should ultimately be to connect a link or open the "gate", between a young person and a school mental health professional.

179

Number of Parents

145

Number of Teachers

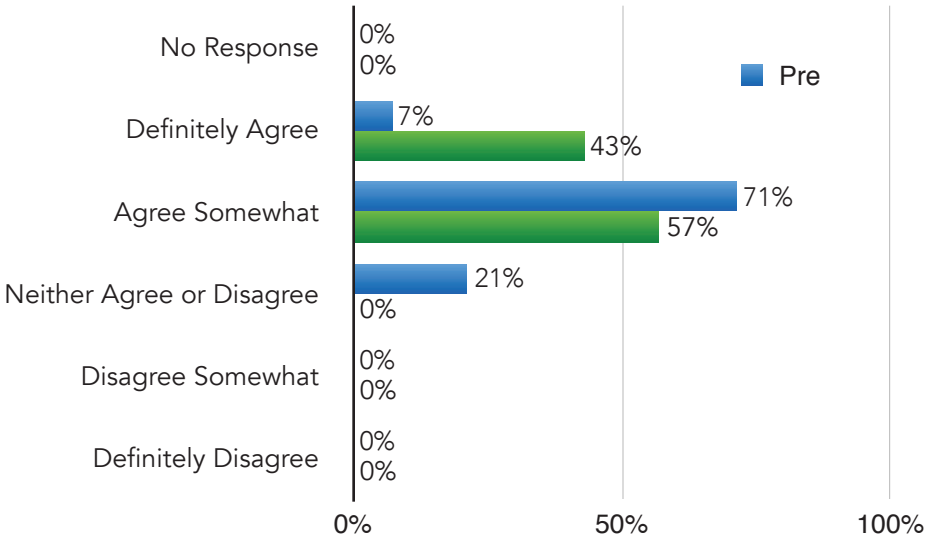
84

Number of School Mental Health Counselors

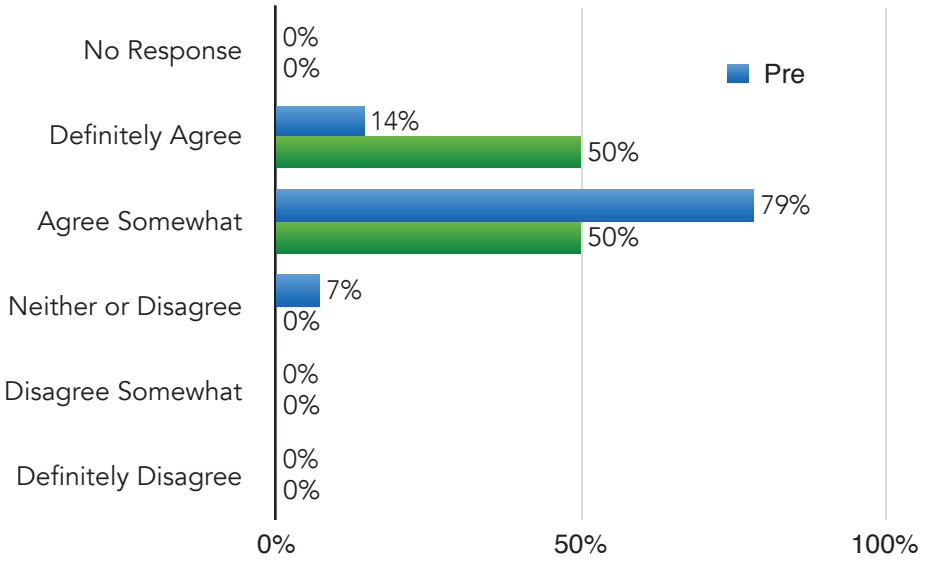
408

Total Number of Teachers, School Mental Staff, & Parents (Goal - 420)

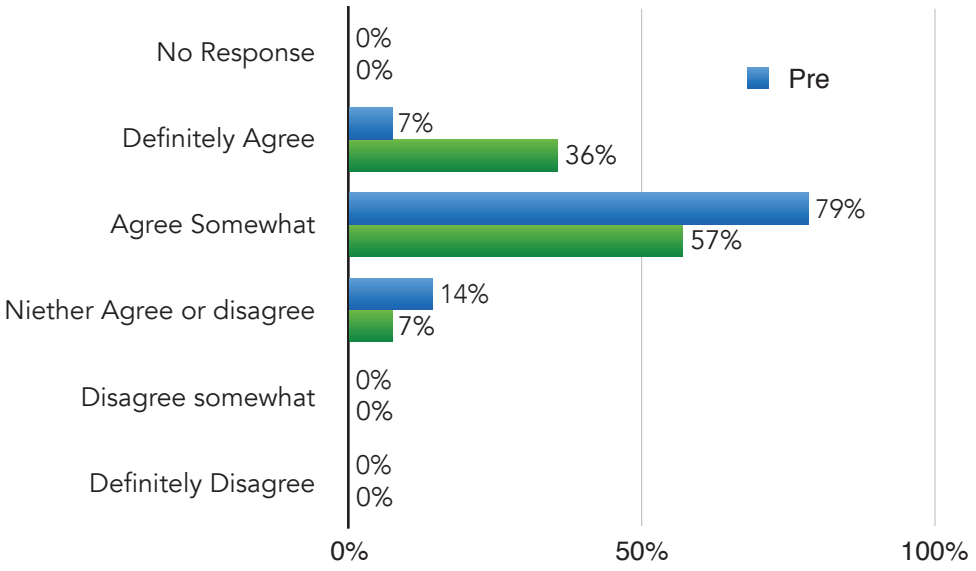
Type of School Gatekeeper Training	School Name/School District/ Organization	Audience
Early Identification & Referral	Emery Unified School District	Teachers
	Holy Spirit School (Oakland)	
	Irvington HS (Fremont USD)	
Teen Mental Health Wellness for Parents	Holy Spirit School (Oakland)	Parents
	Madison Park Academy (Oakland USD)	
	Centerville Jr. High (Fremont USD)	
	Tiburcio Vasquez Health Center (Hayward USD)	
Youth Suicide Assessment & Intervention	Piedmont HS (Piedmont USD)	School Mental Health Staff
	Martin Luther King Jr. MS (Berkeley USD)	
	Willard MS (Berkeley USD)	
	Oakland USD	
	Center for Healthy Schools (Oakland USD)	
	UC Benioff Children's Hospital (Oakland USD)	



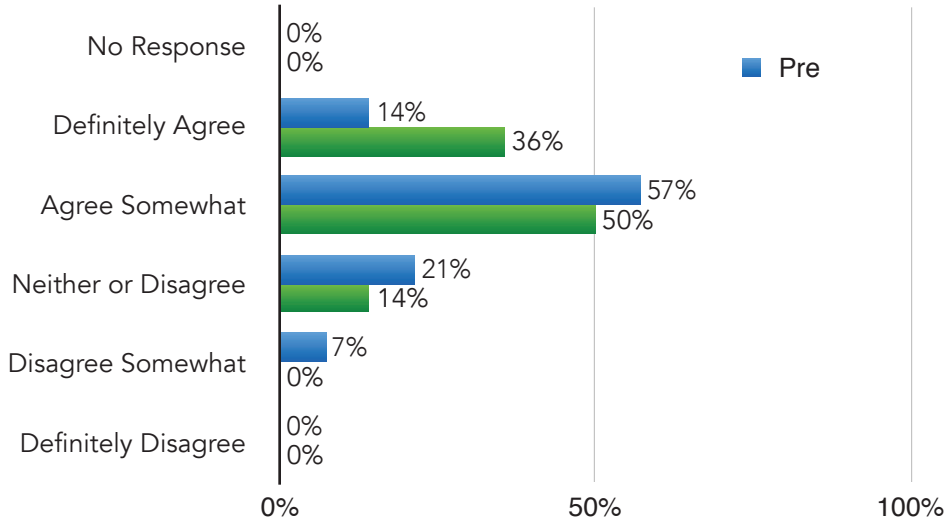
"I can recognize when a person may be suicidal"



"I know the risk and protective factors for suicide"



"I know how to intervene with a suicidal person"



"I feel confident in my ability to communicate appropriately with person who is suicidal "

**Our evaluation tool is composed of 8 content areas that address the 3 main goals of the Teens for Life: School Gatekeeper Curriculum. These content areas allow us to measure whether our goals are being met. Above are highlights. Results of all content areas are available on request.*

Community Gatekeeper Training

What do we know about suicide in our communities?

Suicide is the 10th leading cause of death in the United States (AmericanAssociation of Suicidology, 2013)

Males die from suicide at a rate 3.5 times that of females, however, females attempt suicide 3 times more often than males *(American Association of Suicidology, 2013)*

Population based studies have demonstrated that Lesbian, Gay, Bisexual, and Transgender communities are more likely to attempt suicide than their heterosexual counterparts *(Haas,et.at 2010)*

Suicide rates are highest among those aged 45-54 years old. Older adults and youth are also considered high risk groups.

What do else do we know?

Suicide is preventable. Most suicidal individuals desperately want to live; they are just unable to see alternatives to their problems.

Most suicidal individuals give definite warnings of their suicidal intentions, but others are either unaware of the significance of these warnings or do not know how to respond to them.

What is Gatekeeper Training?

Gatekeeper training generally refers to programs that seek to develop individuals' "...knowledge, attitudes and skills to identify (those) at risk, determine levels of risk, and make referrals when necessary." *(Gould et al., 2003)*

Who are Community Gatekeepers?

Individuals who have face to face contact with community members as part of the usual routine and are trained to identify individuals at risk for suicide and refer them to supportive services. *(U.S. Department of Health & Human Services Office The Surgeon General, National Strategy for Suicide Prevention, 2012)*

Gatekeepers may range from lay citizens to mental health professionals who may be in a position to be among the first to detect signs of suicidality and respond appropriately according to their role.

How do we address suicide in our community?

The mission of our community gatekeeper trainings is to reduce suicide attempts and suicide completions by training and educating community gatekeepers.

Our Community Gatekeeper trainings cover the basics of suicide assessment and intervention; our workshops are routinely tailored to meet specific roles and settings of the audience so that they can more effectively and appropriately engage with their communities. Our Community Education Program recognizes that due to unique characteristics of different age, racial, and ethnic groups, and other historically underserved populations, there are significant disparities in access, availability, and quality of mental health care. There are also key differences in belief systems about suicide and mental health that may affect help-seeking behaviors.

Community Gatekeeper trainings are also considered one of the seven strategies in a comprehensive approach to suicide: Identify people at risk. Often people who are at risk for suicide will not seek help on their own.

Identifying people who are at risk for suicide is an essential strategy if suicide prevention activities are to reach those in the greatest need, one of which are gatekeeper trainings.

How do Community Gatekeeper Trainings and Connectedness relate?

Overall, studies show that connectedness is a protective factor for suicide. According to the Center for Disease Control, connectedness between individuals leads to increased frequency of social contact, lowered levels of social isolation, and an increase in positive relationships. Gatekeepers who have a higher degree of connectedness to individuals in their lives have a greater ability to recognize when someone in their lives are is at risk for suicide. A greater sense of connection also fosters positive coping behaviors (ex. help-seeking) in those who are vulnerable. Our gatekeepers are trained to respond when someone is seeking help through active listening skills and being willing and confident to ask about suicide directly.

Connectedness between individuals and their families to community organizations increase a sense of belonging and provides access to community supports. Gatekeepers are trained to connect someone who is suicidal to crisis and suicide prevention resources, such as our 24-Hour crisis line and teen texline.

Community Gatekeeper Training
Program By the Numbers

710

Number of Community Gatekeepers trained (non-mental health providers)

306

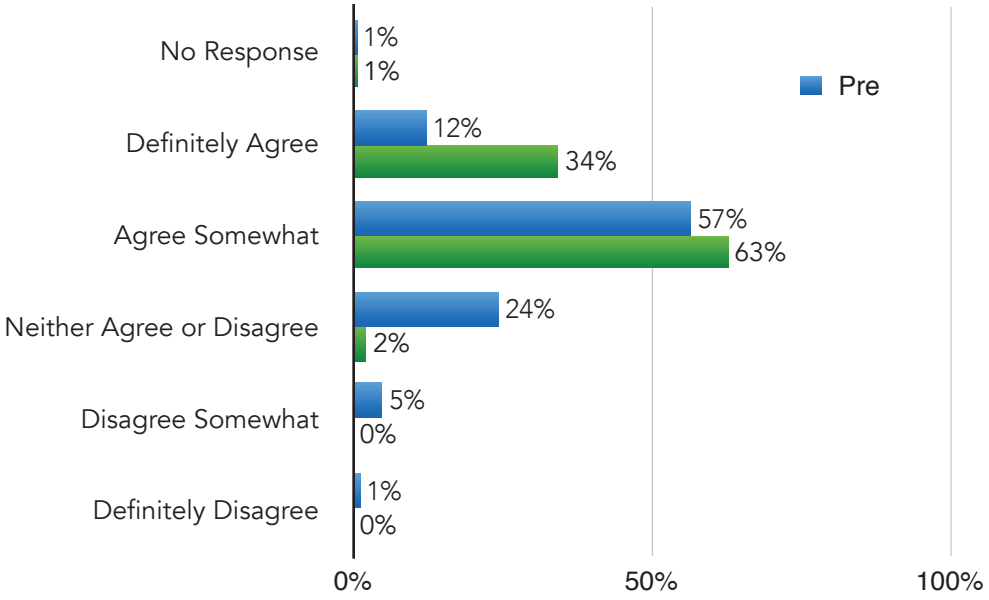
Number of Community Gatekeepers trained who were Mental Health Professionals

1016

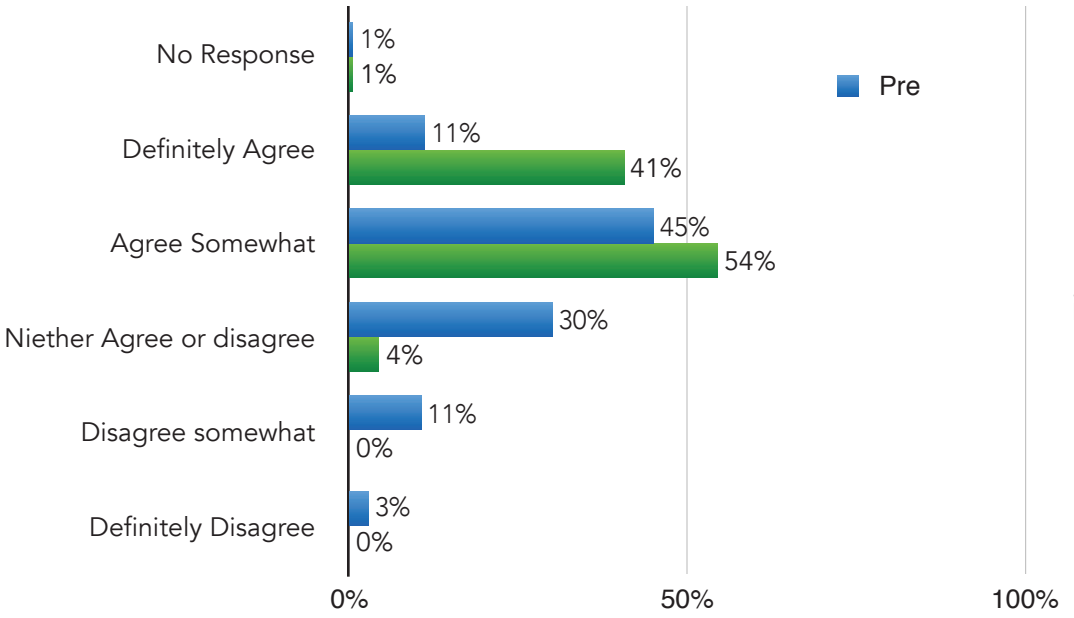
Total Number of Community Gatekeepers Trained (Goal: 600)

Type of Gatekeeper Training	Organization Name	Audience
Basic Community Gatekeeper Training	Cal State East Bay	College Students
	Ohlone College	Faculty
	Samuel Merritt Professional College	Health Care Providers
	Girl's Inc	Service Providers
	Bay Area Women Against Rape	Phone Crisis Line Counselors
	EXHALE	
	Best Now	Certified Peer Counselors
	Bay Area Community Services	Peer Specialists
	PEERS	
	Oakland Police Department	Law Enforcement & Dispatchers
	Alta Bates Summit Medical Center	Hospital Chaplains
	National Alliance on Mental Illness Tri Valley	Families
	Eden I&R	Information and Referral Specialists
Community Gatekeeper Training for Mental Health Professionals	Alameda County Behavioral Health Care Services Barcelon and Associates Seneca Center East Bay Recovery Project Willow Rock Crisis Team Casey Family Programs Horizons Family Services Davis Street Family Services La Cheim Behavioral Health Services Tiburcio Vasquez Health Center HAART Oakland UC Berkeley Psychology Clinic Crisis Support Services of Alameda County	Mental Health Professionals

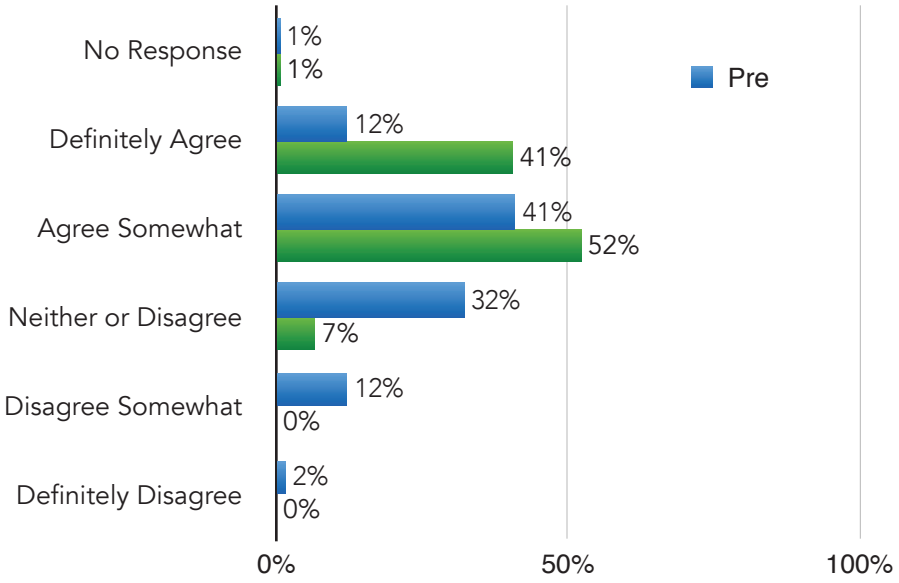
Survey Outcomes* for Mental Health Staff (182 adults)
Average Response Per Item



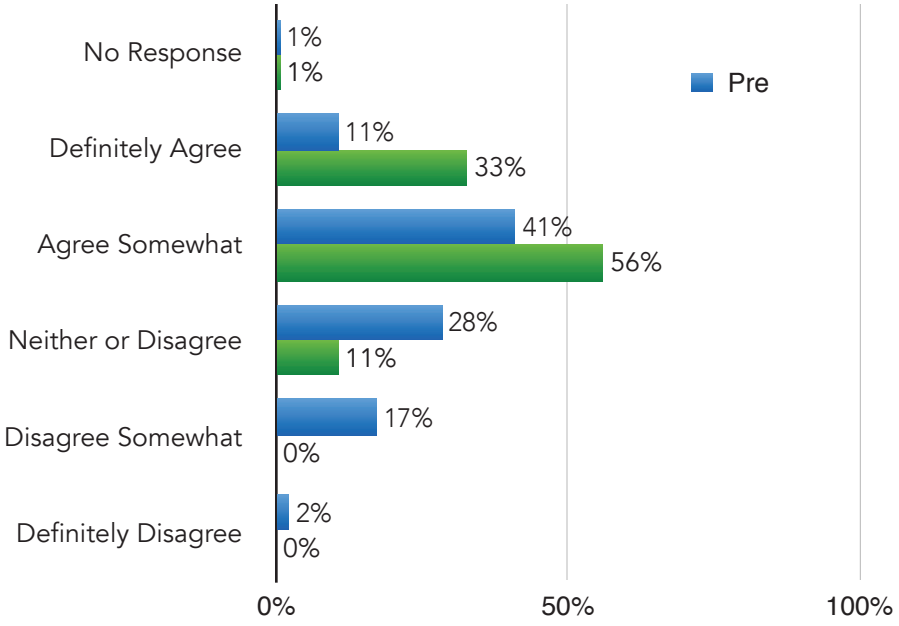
"I can recognize when a person may be suicidal"



"I know how to intervene with a suicidal person"

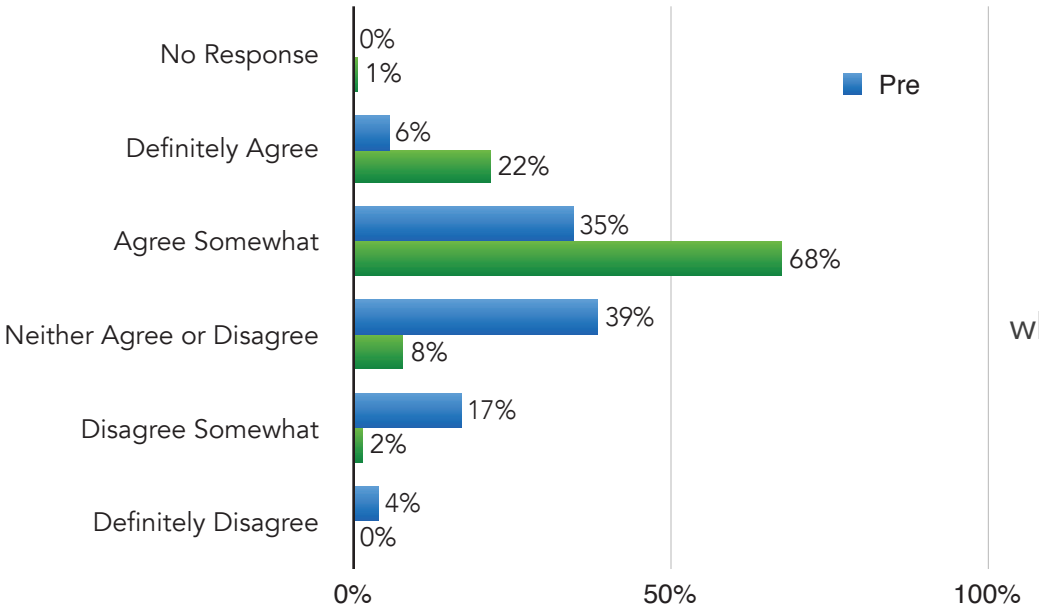


"I feel confident in my ability to communicate appropriately with person who is suicidal "

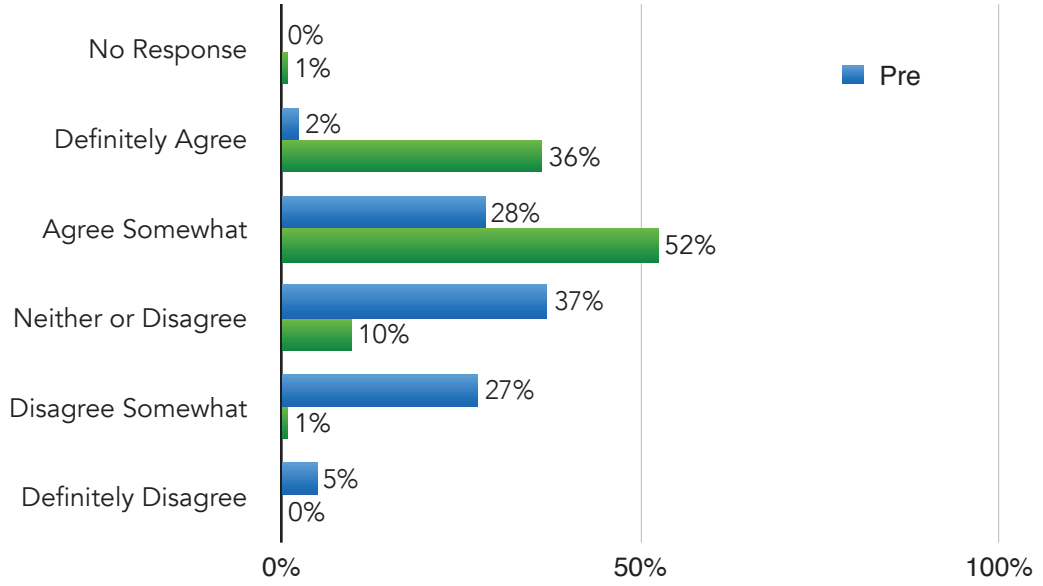


"I feel confident in my ability to determine the level of a person's suicide risk"

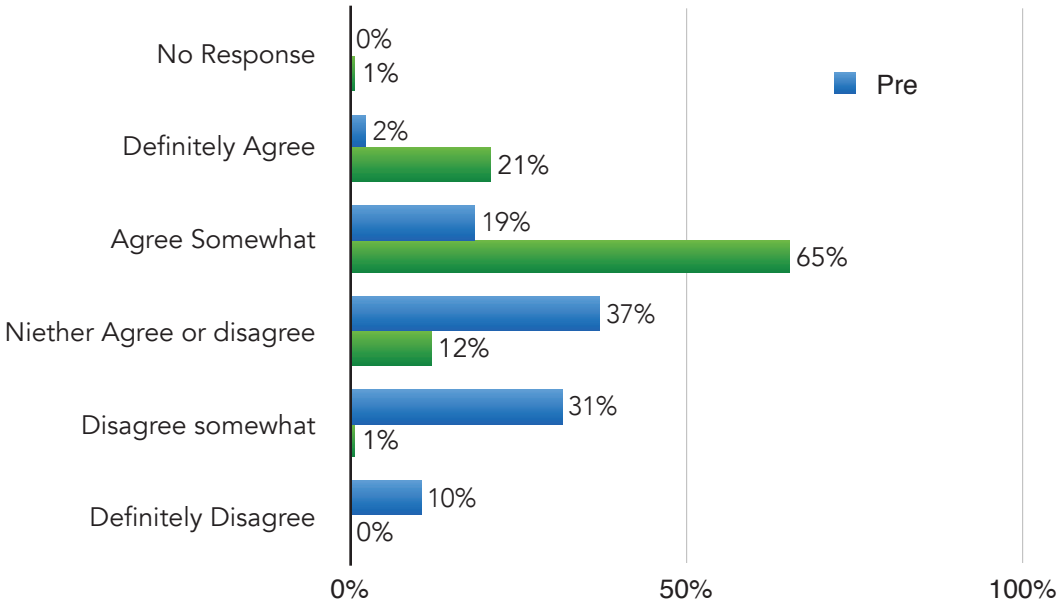
**Above are highlights from 8 content areas we surveyed. Results of all content areas are available on request.*



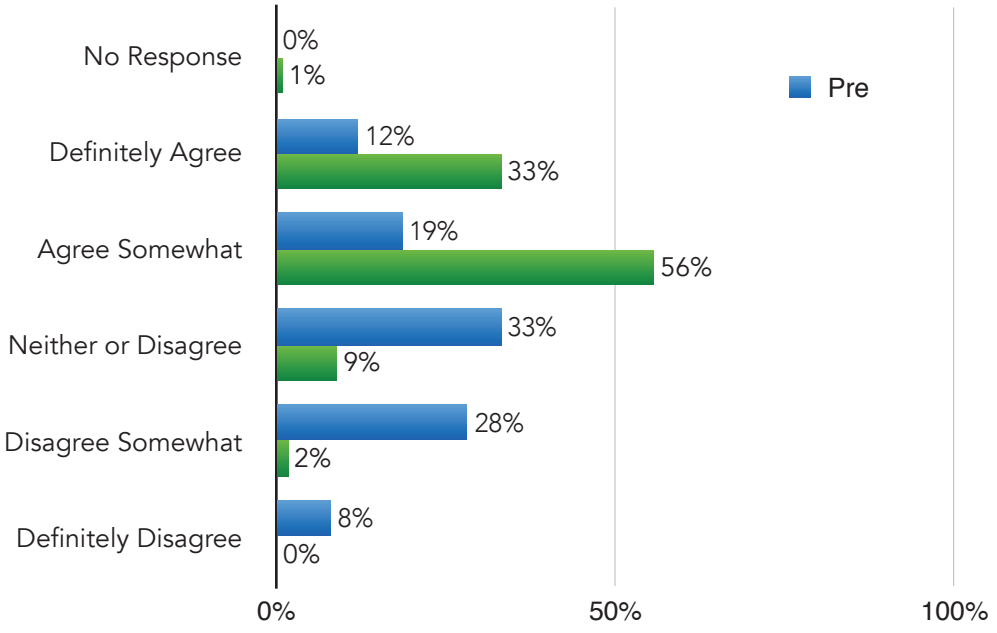
"I can recognize when a person may be suicidal"



"I know the risk and protective factors for suicide"



"I know how to intervene with a suicidal person"



"I feel confident in my ability to ask directly about suicide"

Above are highlights **from 7 content areas we surveyed. Results of all content areas are available on request.*

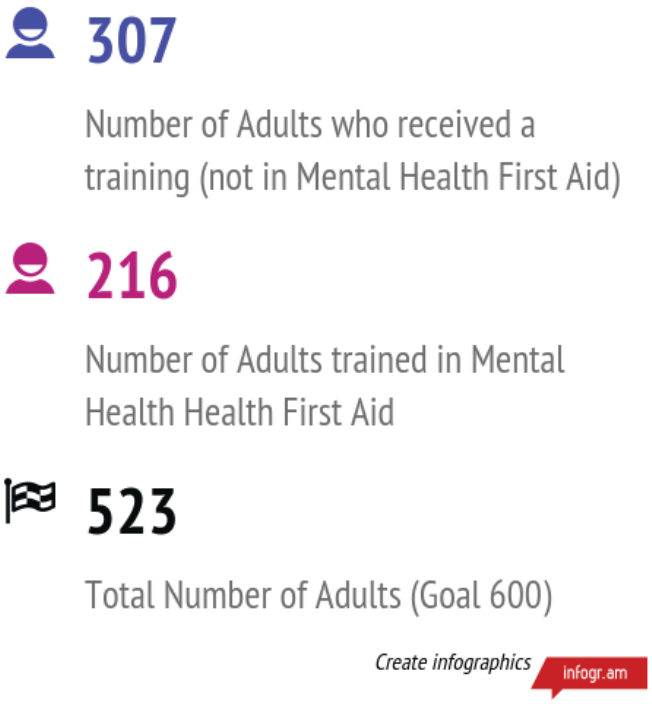
Mental Health Consultation Trainings

Our Mental Health Consultation Trainings are workshops that pertain to general mental health issues, in particular to issues associated with suicide risk. While each workshop are non-suicide specific, they each address suicide and how to help. All workshops, except Mental Health First Aid are created and developed based on community needs and requests. Our most common training provided in this category is Mental Health First Aid (MHFA).

Mental Health First Aid is an 8-hour public education program that helps the public identify, understand, and respond to signs of mental illnesses and substance use disorders. Mental Health First Aid USA is an evidence-based curricula that is provided worldwide. This training is a wonderful example of a program that enhances *connectedness* in our communities. It fosters the fact that we can all play a role in helping someone who may be developing a mental health problem or is experiencing a mental health crisis. Those trained as "mental health first aiders" become part of the safety net of our communities.

Our agency currently has 6 certified Adult MHFA Instructors, three of which are also certified as Youth MHFA Instructors.

Mental Health Consultation Program by the Numbers



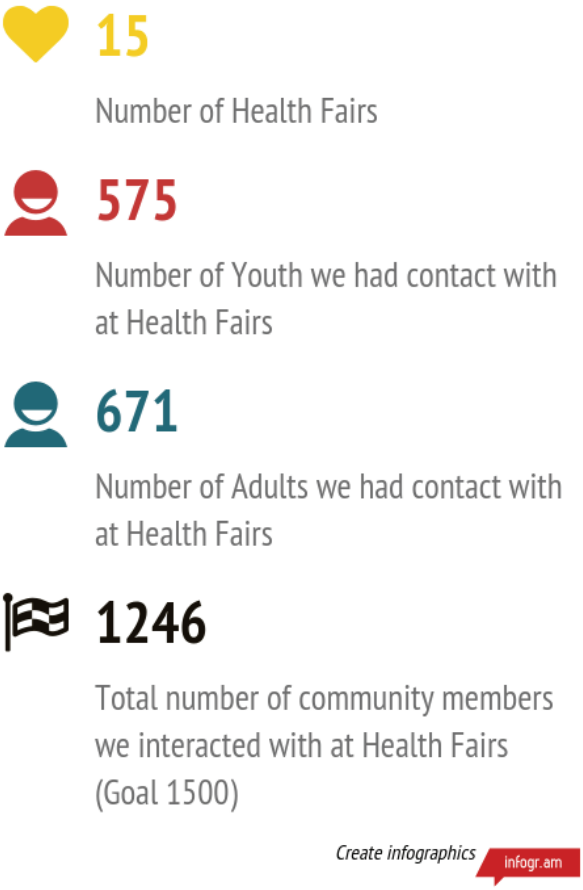
Training	Organization Name	Audience
Bereavement and Older Adults	South Berkeley Senior Center	Older Adults
Mental Health Wellness and Older Adults	East Oakland Senior Center	
Bullying, Cyberbullying, and our Youth	Cherryland Elementary School E.L. Musick Elementary School Ann Martin Center Tiburcio Vasquez Health Center	Parents
	Northern California Educator's Conference	Teachers
Overview of Non-suicidal Self-Injury	Decoto Independent Study Northern California Educator's Conference	
	Piedmont HS	School Mental Health Staff
Working with People with Mental Illness	Life Academy (Oakland USD)	High School Youth
Adult Mental Health First Aid	Alameda County Behavioral Health Care Services	Service Providers
	First 5 Alameda County East Bay Asian Local Development Corporation Bhutanese Service Providers Crisis Support Services of Alameda County National Alliance on Mental Illness Tri Valley	Property Managers
		Refugee Service Providers
		Volunteers and general community
		Families
Youth Mental Health First Aid	Leads Academy	School Staff

Community Suicide Awareness

A vital aspect of suicide prevention is not only to educate the community, but also to promote awareness of suicide prevention resources and foster connectedness to mental health resources.

As an agency, Crisis Support Services of Alameda County takes the opportunity to attend as many health fairs in the community to raise our visibility as a resource.

Community Suicide Awareness
Program By the numbers



Organization/Event Name	Audience
College of Alameda Holy Names University	College Students
City of Newark Senior Center Mercy Housing Mastick Senior Center City of Fremont Senior Health Expo	Older Adults
10x10 Wellness Campaign Alameda County NAMI TriValley Crisis Support Services of Alameda County Hayward Area & Recreation	General Community
Berkeley HS Amador Valley HS	Youth

CHALLENGES & LESSONS LEARNED

Access

Access to teachers and parents in school systems are still an ongoing challenge and process. This can be explained in part that, while we have developed wonderful relationships with a number of the District Mental Health Liaisons, who have been vital in helping us access school administrators, it still takes time to continue to develop individual relationships with school administrators to determine their needs and capacity.

Timing is still key & meeting people where they're at!

In our efforts to reach teachers, we've adjusted our outreach strategy to indicate that our teacher training would be best during their staff development week before school begins, so that they could be assured a full 1-1.5 hours of training rather than the 30 - 45 minutes available during staff meetings. Though we've made some progress at some schools, most are still only able to provide time during staff meetings. What did not work as well was an outreach effort to provide trainings outside of school in local libraries. We determined that we need to continue to meet teachers where they are at.

Surveys from school staff & parents

We were unable to gather the amount of surveys that we needed from teacher trainings. The reason is that there is not enough time to provide a pre/post survey given the limited time provided for our training. It is an issue that we are trying to address. This year most of our trainings for parents were those who were primarily Spanish speaking. While our presentation has been translated to Spanish, unfortunately our pre/post survey for parents is not. This is also a huge lesson learned which we will be rectifying this year.

SUCCESS

Best Practices

One of the Prevention and Early Intervention Initiatives implemented by the California Mental Health Services Authority (CalMHSA), through funding from the Mental Health Services Act (Prop 63), is the Suicide Prevention Initiative. To achieve a suicide prevention–informed California, Didi Hirsch Mental Health Services established the California Suicide Prevention Network (CSPN) in collaboration with ten statewide crisis centers to help build local capacity in suicide prevention and encourage widespread adoption of best practice programs, interventions, curricula and protocols throughout California.

Regional task forces were implemented statewide with representatives from state, county, and local agencies involved in mental health and/or suicide prevention. A Best Practice Workgroup in our region was created to develop suicide prevention curricula for identified priority populations in our region: Lesbian, Gay, Bisexual, and Transgender Older Adults and Law Enforcement. Our Community Education Program Coordinator, Cristina Rita, our Older Adults Counseling Program Director, Devah DeFusco, along with myself were part of this workgroup. This past year, we developed and co-authored the Community Gatekeeper Training named *Lesbian, Gay, Bisexual, and Transgender (LGBT) Older Adults & Suicide Prevention and* contributed to the Law Enforcement curricula (*Mental Health Sight Alignment: Suicide Prevention for Law Enforcement)* safe messaging guidelines.

Both curriculums were adapted from a standardized gatekeeper training module developed and utilized by our Community Education Program. They are 2 of the seven statewide best practices have been customized to meet local needs and to ultimately help to reduce suicide in California. This past spring, both curricula were submitted to the Suicide Prevention Resource Center's Best Practices Registry (SPRC's BPR). **We were pleased**

to hear the great news that our *Lesbian, Gay, Bisexual, and Transgender (LGBT) Older Adults & Suicide Prevention* Gatekeeper training was accepted into the National Best Practice Registry for Suicide Prevention. Already we have received requests nationwide for it's use within local communities. This will be the 2nd curriculum from our agency that is on the Best Practice Registry for Suicide Prevention.

Connectedness Between Community Organizations and Social Institutions

This past year we have had the opportunity to collaborate with two organizations as partners on their federal and local grants. As part of their 3-Year strategic plan to foster mental health wellness and suicide prevention on campus, Ohlone College has asked us to be the providers for suicide prevention education for faculty, staff, and students. In August 2015, we will be providing the first set of trainings to faculty: 1) Suicide Prevention among College Students 2) Mental Health Wellness Among College Students.

La Clinica de la Raza also asked us to be a partner in their project. They established an Internship Program for youth at community based organizations who provide behavioral health care services. Our Teens for Life program hopes to have 1-2 youth interns this year. We want to impart that education and awareness are an important component of behavioral health care. This youth intern will be helping our staff establish the full circle of support to youth at their school site (Life Academy in Oakland) by observing youth presentations, establishing an awareness campaign and connecting us to school staff. This youth intern will also be trained to co-facilitate a youth presentation with us to their peers.

Another ongoing collaborative effort is with the Oakland Police Department. The Oakland Police Department (OPD) provides a training named Crisis Intervention Training (CIT). The CIT program is a model community initiative designed to improve the outcomes of police interactions with people living with mental illnesses. CIT programs are built on local partnerships between law enforcement agencies, mental health providers and advocates, such as the National Alliance on Mental Illness (NAMI). This training involves individuals living with mental illnesses and families at all levels of decision-making and planning. CIT programs typically provide 40 hours of training for law enforcement on how to better respond to people experiencing a mental health crisis.

For the last 4 years, our community education department has been a part of the week-long training by providing Suicide Assessment & Intervention for Law Enforcement. This past year, we also began to provide regular training for their 911 Dispatchers as well as part of their training cycle.

We also have developed on-going relationships with organizations and school sites that include our program into their regular training cycles every year. These include the following:

- Hume Center
- Bay Area Women Against Rape
- EXHALE
- Kaiser Permanente
- Samuel Merritt Professional College
- BEST NOW
- Martin Luther King Jr. MS
- New Haven Unified School District
- Best Now
- Tiburcio Vasquez Health Center

MOVING FORWARD

This coming year brings with it exciting projects!

Trauma Informed Care 101

Alameda County Behavioral Health Care Services has asked our Community Education Program to create a 4-hour "floor training" on trauma-informed care principles to county staff and its community partners. The goal of this training is to encourage our providers to become a trauma informed provider with the hope that clients who receive care do not experience re-traumatization as they receive service. We are currently in the process of creating this curriculum we plan to have it completed by September 2015 for feedback and roll-out. The goal is to provide this training once every Quarter of the fiscal year.

Targeted Outreach

According to population based studies, LGBT communities have higher rates of suicide attempts compared to their heterosexual counterparts. Community Education will be providing an outreach campaign to highlight our newest community gatekeeper training, *LGBT Older Adults & Suicide Prevention.* We will also be providing another workshop developed by the national Suicide Prevention Resource Center, named *Suicide Prevention Among LGBT Youth: A workshop for Professionals who serve Youth.*

According to the Center For Disease Control, suicide is now the second leading cause of death of young people under the age of 24 years old. While we have a curriculum on youth suicide provided both to the general community and providers, it is also important to address other risk factors that are connected with suicide risk among young people. This past year, three of our community education staff became certified as Youth Mental Health First Aid Instructors. We are excited to begin providing this vital training to schools and other organizations who work with young people. This curriculum provides information on how to recognize symptoms and warning signs of common mental health problems among youth. Most importantly, Youth Mental Health First Aid, provides information on how best to engage with young people to convey concern and enhancing connectedness.

News in Teens for Life Program

While we already have the Teens for Life: Youth Curriculum on the Best Practice Registry for Suicide Prevention (BPR), one of our long term goals are to place the **full** Teens for Life Program on the BPR. This year, we are aiming to send our *Teens for Life Program: Early Identification and Referral Training for Teachers* to the BPR.

Thank You One of the most common things said about our crisis lines among staff and volunteers is that when we we pick up the phone, we hold the privilege of being a part of a person's journey to wellness and recovery from despair, hopelessness, and profound isolation. Our role is to reflect a mirror of hope. These are experiences that our education staff bring with them to the community that we hope inspires others to connect and become part of someone else's journey. Thank you so much for your time and your tremendous support.

For questions or to request full data sets: mercedesoleman@crisissupport.org or 510-420-2473

A. COMMUNITY SERVICES & SUPPORTS PROGRAM SUMMARIES

Full Service Partnership (FSP) Programs: The following measures are being adopted by all full service partnership programs and included in future contract language:

Outcome Measures:

1. At least 85 percent of clients (50% for TAY) shall have a primary care within 12 months of enrollment, after being enrolled for at least 12 months.

2. 80 percent of clients shall be in long-term, stable housing within 24 months of enrollment.
    A. Among FSP partners enrolled for at least six months, more than 80% of them at any point in time will be in a known and non-institutional living arrangement (General Living Arrangement or Supervised Placement).
    B. Among FSP partners enrolled for at least six months, at least 60% of partners will have a current living arrangement that is more independent and less restrictive than their living arrangement at the time of admission into the FSP program (Measure based on the FSP housing hierarchy established by the BHCS Housing Services Office and attached).

3. Client use of psychiatric hospitalizations and emergency services shall decrease 50 percent post-enrollment, compared to data for 12 months prior to enrollment.

4. The number of partners incarcerated shall decrease 55 percent within 12 months of enrollment, compared to 12 months prior to enrollment.

5. Employment & Education (being developed further)

Process Measure:

6. 90 percent of the clients who enter the program shall have Medi-Cal application or reinstated benefits within three months of program enrollment. 80 percent (60% for TAY) of the clients who enter the program shall have Supplemental Security Income (SSI), or an open application for SSI, within six months of program enrollment.