MENTAL HEALTH SERVICES ACT
FY 18-19 PLAN UPDATE

alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

WELLNESS • RECOVERY • RESILIENCE

MENTAL HEALTH SERVICES ACT

ALAMEDA COUNTY

FY 2018 - 2019

ANNUAL PLAN UPDATE

RELEASED FOR PUBLIC COMMENT: DECEMBER 6, 2018 – JANUARY 7, 2019

SEND COMMENTS TO: mhsa@acgov.org

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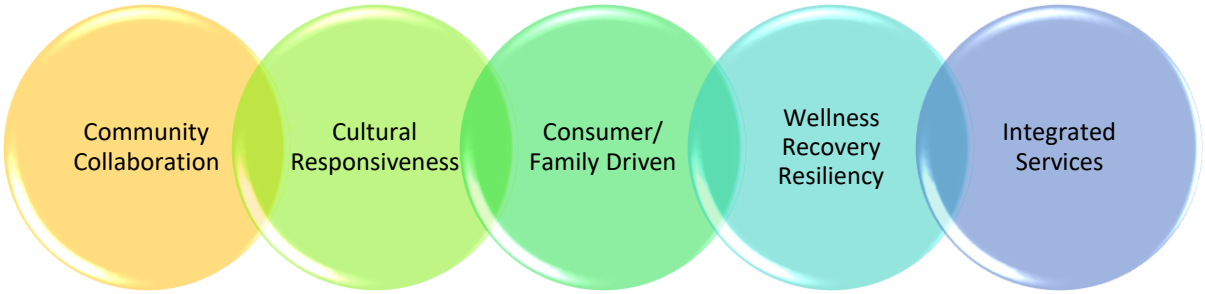
Deputy Director's Message

Thank you for your interest in Alameda County's Mental Health Services Act (MHSA) FY 18/19 Plan Update. The MHSA Annual Update is the opportunity for Behavioral Health Care Services (BHCS) to highlight the accomplishments of the previous fiscal year and communicate stakeholder informed updates for the approved MHSA Three-Year Integrated Plan that spans from FY 2017/18 through FY 2019/20. Our portfolio of programs, services and supports embrace the MHSA Core Values of:



This last fiscal year has been full of activity as BHCS has focused on expanding our Crisis System of Care, and our Full Service Partnership programs. We've also increased our prevention and early intervention (PEI) capacity to outreach and engage underserved and inappropriately served communities through new PEI programs for the Tongan, African, African American, Afghan and Korean communities.

Housing and homelessness for individuals with severe mental illness is another area that's not only a top priority for BHCS, but for Alameda County overall. BHCS is deeply committed to this population and providing a multi-prong approach to reducing homelessness. Our efforts currently include land purchases, partnership developments with local community based organizations, increasing the quality of housing support services, housing navigation services and the development of a new Innovation program called Alameda County Supportive Housing Community Land Alliance. All of this information, and more, can be found in this year's Plan Update.

It is my hope that you find this Annual Update both informative and a reflection of our BHCS vision to empower all individuals and their families to successfully realize their potential and pursue their dreams and where stigma and discrimination against those with mental health and/or substance use issues are remnants of the past.

We look forward to advancing the ideas, activities and programs listed in this Annual Plan Update.

Sincerely,

James Wagner, LMFT/LPCC
Deputy Director of Alameda County Behavioral Health Care Services

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

FY 2018/19 Mental Health Services Act Annual Update
Funding Summary

County: Alameda Date: Date: 12/6/18

	MHSA Funding					
	A	B	C	D	E	F
	Community Services and Supports	Prevention and Early Intervention	Innovation	Workforce Education and Training	Capital Facilities and Technological Needs	Prudent Reserve
A. Estimated FY 2018/19 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	43,244,838	12,853,901	12,720,768	120,619	6,404,607	
2. Estimated New FY 2018/19 Funding	51,934,394	12,983,598	3,416,736			
3. Transfer in FY 2018/19[a/]	(5,369,136)			1,514,607	3,854,529	
4. Access Local Prudent Reserve in FY 2018/19						0
5. Estimated Available Funding for FY 2018/19	89,810,096	25,837,499	16,137,505	1,635,226	10,259,136	
B. Estimated FY 2018/19 MHSA Expenditures	71,635,778	24,981,710	5,145,440	1,635,226	10,259,136	
G. Estimated FY 2018/19 Unspent Fund Balance	18,174,318	855,789	10,992,065	(0)	(0)	

H. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2018	36,210,952
2. Contributions to the Local Prudent Reserve in FY 2018/19	0
3. Distributions from the Local Prudent Reserve in FY 2018/19	0
4. Estimated Local Prudent Reserve Balance on June 30, 2019	36,210,952

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

County: Alameda **Date: 12/6/18**

MHSA Funding Summary, Community Services and Supports (CSS) Component Worksheet

		Fiscal Year 2018/19					
		A	B	C	D	E	F
		Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs							
FSP 1	Homeless Outreach & Stabilization Team	3,338,355	1,953,243	1,385,112			
FSP 2	North County Senior Homeless Program	2,579,820	1,299,614	1,280,206			
FSP 3	Supportive Housing for TAY	2,074,555	1,621,508	453,047			
FSP 4	Greater Hope Project	2,076,141	1,124,170	951,971			
FSP 5	Small Scale Comprehensive Forensic ACT Team	3,176,562	2,185,989	990,573			
FSP 6	Transition to Independence	1,331,908	679,441	652,467			
FSP 7	SSI Advocacy & Support Services	3,147,787	3,143,498	4,289			
FSP 9	Transitional Behavioral Health Court ACT Team	3,522,328	2,767,105	755,222			
FSP 10	Housing Services	12,304,588	11,652,490	652,098			
FSP 11	Community Conservatorship Pilot	761,491	758,044	3,447			
FSP 12	Assisted Outpatient Treatment (AOT) Pilot	1,175,998	1,174,943	1,055			
FSP 13	CHANGES	2,059,328	1,117,197	942,131			
FSP 14	STRIDES	2,060,737	1,118,183	942,554			
FSP 15	STAGES	969,569	749,659	219,910			
FSP 16	Connections Birth to 8	504,860	223,922	280,938			
FSP 17	East Bay Wrap 8-18	501,211	221,368	279,843			
Non-FSP Programs							
OESD 4A	Mobile Integrated Assessment Team for Seniors	655,569	526,088	129,481			
OESD 5A	Crisis Response Program - Capacity for Valley and Tri-City	637,908	382,746	255,162			
OESD 7	MH Court Specialist Program	452,286	353,055	99,231			
OESD 8	Juvenile Justice Transformation of Guidance Clinic	419,212	293,448	125,764			
OESD 9	Multisystemic Therapy	745,318	525,802	219,516			
OESD 11	Crisis Stabilization Service	1,846,576	1,548,918	297,658			
OESD 13	Co-Occurring Disorders Program	530,891	479,937	50,954			
OESD 14	Staffing to Asian Population	957,848	807,660	150,188			
OESD 15	Staffing to Latino Population	773,558	632,810	140,748			
OESD 17	Residential Treatment for Co-occurring Disorders	2,871,490	2,343,681	527,809			
OESD 18	Wellness Center	3,538,987	2,993,602	545,385			
OESD 19	Medication Support Services	2,836,825	1,829,486	1,007,339			
OESD 20	Individual Placement Services	3,800,540	2,677,723	1,122,817			0
OESD 23	Crisis Residential Services	3,971,401	3,734,700	236,701			
OESD 24	Schreiber Center	406,084	284,259	121,825			
OESD 25	Behavioral Health - Primary Care Integration Project	7,163,174	6,224,741	938,433			
OESD 26	Culturally-Responsive Treatment Programs for African-American C	998,062	998,062				
OESD 27	In Home Outreach Team	2,706,885	2,706,885				
OESD 28	SAGE Case & Care Management	2,689,396	2,689,396				
OESD 29	Older Adult Service Team	786,959	786,959				
OESD 30	Peer Respite	795,896	795,896				
CSS Administration		9,364,403	6,229,549	3,134,854			
CSS MHSA Housing Program Assigned Funds		0					
Total CSS Program Estimated Expenditures		90,534,506	71,635,778	18,898,728	0	0	0
FSP Programs as Percent of Total		58.1%					

County: Alameda **Date: 12/6/18**

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

		Fiscal Year 2018/19					
		A	B	C	D	E	F
		Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention							
PEI 1A	School-Based Mental Health Consultation in Preschools	953,885	844,507	109,378			
PEI 1B	School-Based Mental Health Access & Linkage in Elementary, Middle, & High Schools	1,696,512	1,696,512				
PEI 1C	Early Childhood Mental Health Outreach & Consultation	300,000	300,000				
PEI 1D	Unaccompanied Immigrant Youth Outreach	724,542	724,542				
PEI 1E	School-Based Mental Health Outreach	157,626	157,626				
PEI 1F	Community-Based Mental Health Outreach & Consultation	161,568	161,568				
PEI 4	Stigma & Discrimination Reduction Campaign	1,395,875	1,364,514	31,361			
PEI 5	Outreach, Education & Consultation for Latino Community	1,277,254	1,035,907	241,347			
PEI 6	Outreach, Education & Consultation for Asian Pacific Islander Commu	2,575,210	2,349,161	226,049			
PEI 7	Outreach, Education & Consultation for South Asian/Afghan Commun	1,430,000	1,363,464	66,536			
PEI 8	Outreach, Education & Consultation for Native American Community	294,888	238,669	56,219			
PEI 9	Outreach, Education & Consultation for Middle Eastern Community	290,000	234,000	56,000			
PEI 10	Outreach, Education & Consultation for African Community	289,901	233,901	56,000			
PEI 12	Suicide Prevention and Trauma-Informed Care	1,918,260	1,837,346	80,914			
PEI 13	Wellness, Recovery and Resiliency Services	2,746,740	2,572,113	174,627			
PEI 14	Family Education & Resource Center (FERC)	1,718,538	1,684,982	33,556			
PEI 17AB	TAY Resource Centers	876,978	724,578	152,400			
PEI 19	Older Adult Peer Support	279,724	279,724				
PEI 20A	Culturally Responsive PEI programs for the African American Community, TAY Supports	279,450	279,450				
PEI 20B	Culturally Responsive PEI programs for the African American Community, Speakers Bureau	70,000	70,000				
PEI 20C	Culturally Responsive PEI programs for the African American Community, Family Supports	38,036	38,036				
PEI 20D	Culturally Responsive PEI programs for the African American Community, Emotional/Empowerment Groups	415,227	415,227				
PEI 20E	Culturally Responsive PEI programs for the African American Community, Faith-based programs	208,658	208,658				
PEI 22	LGBT Support Services	327,944	327,944				
PEI 23	Post Crisis Peer Mentorship	330,526	330,526				
PEI Programs - Early Intervention							
PEI 2	Early Intervention for the Onset of First Psychosis & SMI Among TAY	1,266,776	820,958	445,818			
PEI 3	Mental Health for Older Adults, Geriatric Assessment & Response Team (GART)	853,699	597,589	256,110			
PEI Administration		5,212,422	3,985,766	1,226,656			
PEI Assigned Funds		104,442	104,442				
Total PEI Program Estimated Expenditures		28,194,681	24,981,710	3,212,971	0	0	0

County: Alameda **Date: 12/6/18**

MHSA Funding Summary, Innovation (INN) Component Worksheet

	Fiscal Year 2018/19					
	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	1,339,732	1,339,732				
2. Children & Youth	1,000,000	1,000,000				
3. Alternative Transport	2,018,597	2,018,597				
4. TAY Cannabis	153,375	153,375				
5. TAY EEC	150,000	150,000				
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	583,909	483,736	100,173			
Total INN Program Estimated Expenditures	5,245,613	5,145,440	100,173	0	0	0

County: Alameda **Date: 12/6/18**

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

	Fiscal Year 2018/19					
	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
WET Programs						
1. Workforce Staffing Support	492,192	492,192				
2. Staff Development, Training/Confernece and Consultan	30,000	30,000				
3. High School and Community College Pipeline Programs	21,500	21,500				
4. The ACBHCS Traiing Institute	112,479	112,479				
5. Post Graduate Certificate Program	143,055	143,055				
6. Psychiatry and Integrated Behavioral Health Care	311,000	311,000				
7. Graduate Intern Stipend Program	125,000	125,000				
8. Loan Assumption Program	400,000	400,000				
9.	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	1,635,226	1,635,226	0	0	0	0

County: Alameda **Date: 12/6/18**

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

	Fiscal Year 2018/19					
	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
CFTN Program - Capital Facilities Projects						
1. Mental Health Wellness Center	392,627	392,627				
2. South County Homeless Project	687,913	687,913				
3. Villa Fairmont Renovation	754,000	754,000				
4. Alameda Point Collaborative	500,000	500,000				
5. Sonoma Street Parking Lot	600,000	600,000				
6. Crisis Residential Treatment & Stabilizatio	3,000,000	3,000,000				
7.	0					
8.	0					
9.	0					
10.	0					
CFTN Program - Technological Needs Projects						
11. Behavioral Health Management System	1,888,180	1,888,180				
12. Web-based dashboard	97,000	97,000				
13. County Equipment & Software Update	1,300,000	1,300,000				
14. Technical Assistance	225,000	225,000				
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
CFTN Administration	814,416	814,416				
Total CFTN Program Estimated Expenditures	10,259,136	10,259,136	0	0	0	0

SUMMARY OF CHANGES FROM PREVIOUS PLAN (FY 17/18)

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[1].

I. COMMUNITY SERVICES AND SUPPORTS
- a. Full Service Partnerships RFP Update
- b. Outreach, Engagement and System Development (OESD) Programs focused on the African American Community Update

II. PREVENTION AND EARLY INTERVENTION (PEI)
- a. PEI Programs focused on the African American Community Update
- b. Underserved Ethnic and Linguistic Populations (UELP RFP)
- c. New Time-limited PEI Programs

III. INNOVATION
- a. INN Programs under Procurement
- b. New INN Programs under Development for Future Procurement

IV. WORKFORCE DEVELOPMENT AND TRAINING (WET) / CAPITAL FACILITIES AND TECHNOLOGICAL (CFTN) NEEDS

I. COMMUNITY SERVICES AND SUPPORTS

a. Peer Respite Center

In September 2018, the Alameda County Board of Supervisors approved the launch of the new Alameda County Peer Respite Program which will provide a community-based, unlocked respite facility that will be staffed 24 hours per day and will offer voluntary, recovery support services.

The facility will be run by La Familia Counseling Service and will be centrally located in Hayward. There will be six beds available for peer respite services to support each client for up to 14 days and will be staffed by people with lived experience. The program is projected to provide peer respite to approximately 37 unduplicated clients in FY 2018-19 and to approximately 75 unduplicated clients per year thereafter.

Expanded peer support is one of the programs in Alameda County which was identified through the Assembly Bill 1421 (AB 1421) community stakeholder process as a key local strategy for

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

providing mental health crisis support.

b. FULL SERVICE PARTNERSHIP PROGRAMS, PROCUREMENT COMPLETED

Full-Service Partnerships

The re-bidding and expansion of the Full-service Partnerships (FSP) through a competitive request for procurement (RFP) process was completed in FY 17/18 with a start date of October 1, 2018 (FY 18/19). The FSP programs provide our highest level of community based care & coordination services. This RFP process has allowed BHCS to increase the number of existing partners to be served as well as creating two new FSPs for children birth to 8 and 8-18. Below are the names and awarded recipients and the programs they will operate:

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

c. Outreach, Education and System Development (OESD) Programs in Development for the African American Community

1. **Request for proposal Updates:** On November 30, 2017 BHCS released a Request for Interest (RFI) #17-11 to identify qualified Bidders to provide mental health programs specifically designed for Alameda County African American communities and to solicit community feedback on proposed programs.

   BHCS also offered technical assistance to respondents to the RFI that had not previously contracted with BHCS and indicated an interest in receiving training and technical assistance on the procurement and contracting process.

In FY 18/19 BHCS expects to fulfill the $1,000,000 ongoing funding allocation in MHSA CSS funding for services designated to the African American community. The table below provides a procurement update for the three project areas that will be funded under CSS.

Program	Service Overview	Procurement Status
Re-entry Mental Health Services	The awarded program will provide mental health services to African American adults with severe mental illness (SMI) who've been arrested or charged with a crime, released from jail or prison, on probation, and/or discharged from parole with release. Program services shall focus on the North and Central regions of the County.	• RFP was released 9/20/18, with all bids due 10/30/18. • Estimated contract start date 3/2019.
Support Services at MHSA Funded Housing Sites	The awarded program will provide site-based emotional/mental health supportive services in (MHSA funded) permanent supportive housing sites and subsidized licensed board and cares throughout Alameda County.	• RFP is in development and will be released in FY 18/19
Training and Technical Assistance on accurate diagnosis and treatment & healing practices	This program will provide: 1) technical assistance and support to mental health providers in better serving African American communities and 2) Development of trainings for mental health providers on accurate diagnosis, treatment, and healing practices for African American communities.	• RFP is complete. The identified provider, Hiawatha Harris dba Pathways to Wellness, will begin services in FY 18/19.

2. **Planning for an African American focused Wellness Center is continuing in FY 18/19.** Funding for this phase of the Wellness Center will allow for vetting of the initial proposal that was previously developed and assist with planning of wellness services that honor traditional practices, reflect holistic, culturally congruent wellness and healing approaches, and builds upon the integrity and humanity of the African American community.

II. PREVENTION AND EARLY INTERVENTION (PEI)

a. PEI Programs focused on the African American Community

On November 30, 2017 BHCS released a Request for Interest (RFI) #17-11 to identify qualified Bidders to provide mental health programs specifically designed for Alameda County African American communities and to solicit community feedback on proposed programs.

In FY 18/19 BHCS expects to fulfill the $1,000,000 ongoing funding allocation in MHSA PEI

funding for services designated to the African American community. The table below provides a procurement status update for the two final project areas that will be funded under PEI.

Program	Service Overview	Procurement Status
Empowerment/ Healing Mental Health Support Groups	The awarded program will develop and implement a culturally responsive mental health support group curriculum to support participants in using their voices and experiences to address their mental health needs.	• RFP was released 7/18, with all bids due 9/18. • Estimated contract start date 11/2018
Faith-based Mental Health Trainings	The awarded program will develop a training curriculum and stigma reduction campaigns for faith-based groups to support their communities in addressing the mental health needs of consumers and their family members. Faith-based groups may include churches, congregations, and/or religious or spiritual organizations. Workshops/trainings as well as ongoing mental health consultation for faith leaders will also be provided through this program.	• RFP was released 10/11 with all bids due 11/18. • Estimated contract start date 3/2019

b. Underserved Ethnic and Linguistic Populations (UELP) RFP

In October 2017 BHCS released a Request for Proposal (RFP) #17-09 to seek proposals for the provision of Prevention and Early Intervention (PEI) services to families and individuals of all ages who identify as part of Unserved or Underserved Ethnic and Language Populations (UELP) in Alameda County. BHCS will use this RFP to establish up to twelve contracts to provide services to the following priority populations:

- Afghan
- African
- Asian
- Middle Eastern and Arabic
- Native American
- Native Hawaiian, other Pacific Islanders and Filipino
- South Asian
- Southeast Asian

The majority of these contracts began in July 2018 (FY 18/19). This RFP process has brought in four new agencies to BHCS and one crossover agency that has a substance use disorder contract, and will now also have a mental health contract.

c. New Project for the Sobrante Park Neighborhood

In March 2018, BHCS released an RFP for a time limited (up to 3 years) prevention and early intervention project for the Sobrante Park Community. The RFP was awarded to Roots Community Health Center. This project is linked to the 2007 Violence Prevention Blueprint and the Violence Prevention Initiative (VPI) chaired by Supervisor Nate Miley, District 4. BHCS has procured Prevention services through this RFP to reduce the risk factors for developing a potentially serious mental illness and to build protective factors for resiliency. Services will be designed to address Objectives 1-3 of the Alameda County Violence Prevention Blueprint: "*Promote Positive Child and Youth Development; Ensure Supported and Functioning Families;* and *Foster Safe and Vibrant Neighborhoods."*

d. Trauma Informed Care Training and Capacity Building Services

In September 2018, BHCS released an Informal Request for Proposals (IRFP) for a time limited prevention and early intervention project to expand organizational awareness of trauma and Trauma Informed Care (TIC) practices, build TIC systems infrastructure within Behavioral Health Care Services, and serve as a bridge between organizational providers, county departments, and agencies outside BHCS.

The selected agency shall implement a multi-prong approach to TIC system development and capacity building for the BHCS workforce. This approach will include the development of a cohort of TIC trainers (through a train the trainer model) for the purpose of expanding BHCS' capacity to offer TIC trainings and presentations to the BHCS workforce, provider community and other interested public agencies. Additional activities to be built into this approach include ongoing technical assistance and consultation in the areas of trauma and TIC principles, leadership and system development and the creation & distribution of TIC informational materials relevant to Alameda County and BHCS.

III. INNOVATION (INN)

a. Approved INN Programs being Implemented in FY 18/19

In October 2018 BHCS had three INN programs approved by the Mental Health Services Oversight and Accountability Commission. The programs include:

- Community Assessment and Transport Team (CATT)
- Transitional Age Youth Emotional Emancipation Circles
- Introducing Neuroplasticity to Mental Health – A Holistic Approach to Intervening With Children

A summary of each of these projects are included in the Innovation section of this Plan Update.

b. New INN Programs under Development for Future Procurement

Alameda County Behavioral Health Care Services (BHCS) is currently exploring several new proposals for the Innovation component of the Mental Health Services Act. One of the proposals is the Alameda County Supportive Housing Community Land Alliance. This is a five year project that will promote interagency and community collaboration among BHCS staff, family members, consumers, and affordable housing developers to create a community land trust focused on preserving and creating supportive housing units for BHCS consumers. The proposed approach increases Alameda County's ability to secure and maintain affordable housing with linked supportive services for BHCS consumers by:

- Leveraging public and private investments in a single property, including family member and client ownership opportunities;
- Building an organization with supportive housing property management and housing partnership expertise necessary to secure housing units for BHCS consumers when opportunities arise;
- Using a nonprofit structure to preserve the use of land and associated structures for sustaining supportive housing units for people with histories of serious mental illness

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

IV. WORKFORCE DEVELOPMENT AND TRAINING (WET) AND CAPITAL FACILITIES AND TECHNOLOGICAL NEEDS (CFTN)

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

a. New WET Programming

BHCS is partnering with Cal State East Bay on a, time-limited (2-year), Infant & Early Childhood Mental Health Post Graduate Certification Program. The overarching goal is to build capacity in a culturally diverse early childhood workforce to meet the specialty early childhood mental health needs of young children and families in Alameda County.

This program was developed based on community input from the early childhood community during BHCS' Three Year MHSA Plan planning process in FY 17/18.

b. New Capital Facilities & Technological Needs (CFTN) Projects

Housing and homelessness for individuals with severe mental illness as well as access to crisis services continue to be a top priority for BHCS. During FY 18/19 the following CFTN projects will be developed. Some projects will be completed in FY 18/19 and others will continue through FY 19/20.

1. **Land Purchase:** BHCS has used its AB 114 CFTN funds to purchase a small plot of land next to the A Street Shelter, this has been documented in a Board letter titled, the purchase of "real property at 22385 Sonoma Street, Hayward".

   BHCS has been operating the A Street Homeless Shelter in Hayward since 1988. The subject lot is located at 22385 Sonoma Street immediately adjacent to the existing A Street Shelter. The approximately 6,250 square feet unimproved lot is vacant. BHCS plans to use the lot as additional parking, providing approximately 20 additional spaces to augment the inadequate parking capacity needed to serve employees, residents, visitors and service vehicles. This land may be augmented in the future to expand the A Street Shelter capacity.

2. **Investment in permanent supportive housing and medical/psychiatric respite for Older Adults who are homeless:** On July 10, 2018, the Alameda County Board of Supervisors declared a shelter crisis in our County upon a finding that a significant number of persons within the County are without the ability to obtain shelter and that the situation has resulted in a threat to the health and safety of those persons. The Health Care Services Agency (HCSA) seeks strategies to address the crisis, understanding that medically frail and aging homeless individuals face exposure and trauma, worsening conditions, premature mortality and risk dying alone on the streets.

   BHCS, as part of HCSA, is in alignment with HCSA's vision of developing multiple strategies to reduce homelessness. To this point, BHCS will utilize AB 114 CFTN funds to invest in a project through a local nonprofit, Alameda Point Collaborative (APC), to provide start-up funding for a development that will provide permanent supportive housing, medical respite and extended care to people experiencing homelessness, with an emphasis on medically frail and individuals with complex medical and psychiatric needs. APC has initiated the development of a Senior Housing and Medical Respite Center (Center) to help alleviate the homelessness crisis and address adverse health outcomes among vulnerable populations in Alameda County.

   The project will renovate and adaptively re-use the five existing buildings at the site, located on McKay Avenue next to Crab Cove in Alameda. The Center will provide the following programs:

   - 90 units "Assisted Living" – permanent supportive housing
   - 38-bed Medical Respite program
   - 12-bed Extended Care
   - Federally Qualified Health Clinic (FQHC)
   - Coordinated Entry Service Hub
   - Resource Center and Drop-In Center

3. **Investment in Facility Development for the Berkeley Wellness Center:** Alameda County, BHCS and the City of Berkeley have agreed to jointly develop a Wellness Center for the City of Berkeley in order to serve north county residents who have a mental health diagnosis or have experienced mental health challenges who will benefit from a cohesive set of wellness and recovery services. BHCS will dedicate AB 114 CFTN funds to develop this facility.

4. **Planning for a New Crisis and/or Transitional Housing Project targeted for the East Oakland Community:** In line with BHCS' goals of increasing access to crisis services and transitional housing, BHCS has started the process of working with county partners to identify and renovate space that will ultimately become a licensed crisis residential treatment program and/or transitional housing units for adults who have a serious mental illness and are in need of transitional stable housing. Based on current crisis service sites, housing needs and building availability this project is to be located in East Oakland. More information will be provided as it becomes available.

5. **Investment in the final construction stages of the new dual crisis stabilization unit (CSU) and crisis residential treatment (CRT) program, Amber House, located in North Oakland:** The State of California, through Senate Bill (SB) 82: Investment in Mental Health Wellness Act of 2013, allows counties to apply for grant funds for the purpose of expanding crisis services and facilities. Alameda County has been awarded grant funds under SB82 to develop a 14-bed crisis residential treatment program operating in tandem with a 12-bed crisis stabilization program. BHCS has, with County Board authorization, partnered with the local community-based mental health provider, Bay Area Community Services (BACS), to utilize these grant funds by developing a facility named Amber House in Oakland. BHCS is currently working with the General Services Agency (GSA) to determine a final timeline, construction deliverables and costs. MHSA funds will be used to leverage the final construction costs.

   It's anticipated that the development of a CSU/CRT program will significantly reduce overcrowding at John George and reduce the impact on the emergency department of local hospitals while providing more accessible services to the residents of Alameda County. This increase supports BHCS's ultimate goal of expanding the County's number of beds at facilities throughout Alameda County.

Alameda County Demographics

The Bay Area is the fourth-largest metropolitan area in the United States. Among the Bay Area counties in 2016-2017, Alameda County experienced the highest numeric increase with approximately 10,000 people. Alameda County experienced 10,016 people in international migration, second only Santa Clara County in the Bay Area. [1]

In 2017, Alameda County was home to 5.9% children (0-5yrs. old), youth (6-17yrs. old), 59.9% adults (18-59 yrs. old) and 13.5% older adults (60+ yrs. old). Population in the County increased by 10.1%, four percent more than the State.

Alameda County ranks one of the most diverse counties consisting of White (50.2%), Asian (31.3%), Latino (22.5%), and African American (11.3%), Native American (1.1%), Pacific Islander/ Native Hawaiian (1%) and Two or more races (5.9%). Asian, Pacific Islander, and African American populations of Alameda County are each approximately double the State's same populations.

Table 1: Alameda County Demographics

U.S. Census Bureau, Population estimates, July 1, 2017, (V2017)

GEOGRAPHY		
Geography	Alameda County	California
Population per square mile, 2010	2,043.6	239.1
Land area in square miles, 2010	739.02	155,779.22

PEOPLE		
Population	Alameda County	California
Population estimates, July 1, 2017, (V2017)	1,663,190	39,536,653
Population estimates base, April 1, 2010, (V2017)	1,510,261	37,254,518
Population, percent change - April 1, 2010 (estimates base) to July 1, 2017, (V2017)	10.1%	6.10%
Population, Census, April 1, 2010	1,510,271	37,253,956
Age and Sex		

[1] *Source: U.S. Census Bureau, Population Division, March 2018.*

Persons under 5 years, percent	5.9%	6.30%
Persons under 18 years, percent	20.7%	22.90%
Persons 65 years and over, percent	13.5%	13.90%
Female persons, percent	50.8%	50.30%
Race and Hispanic Origin		
White alone, percent(a)	50.2%	72.40%
Black or African American alone, percent(a)	11.3%	6.50%
American Indian and Alaska Native alone, percent(a)	1.1%	1.60%
Asian alone, percent(a)	31.1%	15.20%
Native Hawaiian and Other Pacific Islander alone, percent(a)	1.0%	0.50%
Two or More Races, percent	5.3%	3.90%
Hispanic or Latino, percent(b)	22.5%	39.10%
White alone, not Hispanic or Latino, percent	31.5%	37.20%
Population Characteristics		
Veterans, 2012-2016	56,099	1,720,635
Foreign born persons, percent, 2012-2016	31.7%	27.00%
Housing		
Housing units, July 1, 2017, (V2017)	606,052	14,176,670
Median gross rent, 2012-2016	$1,432	$1,297
Families & Living Arrangements		
Households, 2012-2016	564,293	12,807,387
Persons per household, 2012-2016	2.79	2.95

Language other than English spoken at home, percent of persons age 5 years+, 2012-2016	43.9%	44.00%
Education		
High school graduate or higher, percent of persons age 25 years+, 2012-2016	87.3%	82.10%
Bachelor's degree or higher, percent of persons age 25 years+, 2012-2016	43.9%	32.00%
Health		
With a disability, under age 65 years, percent, 2012-2016	6.1%	6.80%
Persons without health insurance, under age 65 years, percent	5.3%	8.10%
Income & Poverty		
Median household income (in 2016 dollars), 2012-2016	$79,831	$63,783
Per capita income in past 12 months (in 2016 dollars), 2012-2016	$39,042	$31,458
Persons in poverty, percent	10.7%	13.30%

Alameda County Challenges

Every two years, the initiative, Alameda County Everyone Counts, conducts comprehensive counts of the homeless population in Alameda County to measure the prevalence of homelessness. The 2017 Point-In-Time Count recorded 5,629 people experiencing homelessness the night of January 30, 2017. Sixty nine percent were unsheltered—living in tents, parks, vehicles, vacant buildings, underpasses, etc. Eighty two percent of respondents said they lived in Alameda County before becoming homeless, with 50% of those individuals having lived in Alameda County for 10 years or more. Only 2% of respondents were not interested in housing. Shelters and transitional housing were full at the time of the Homeless Count, with 1,766 people staying in them. Each year, at least 1,500 individuals transition to permanent housing, while over 2,500 people become homeless. More than half of respondents said that economic hardship was the primary cause of their homelessness. Median rents have increased 25% since 2015 while median household income increased only 5%. Alameda County has also lost 74% of state and federal funding for affordable housing production, creating a shortage of housing units (Everyone Home Alameda Count, 2017).

Alameda County is burdened with the third largest population of "extremely low income" households in California, behind San Francisco and Los Angeles. Seventy percent of the extremely low income households are spending more than 50% of their income on rent. Alameda County needs 60,173 more affordable rental homes to meet the needs of the lowest income renters. In Alameda County, the median asking rent is approximately three times higher than the maximum CalWorks grant for a family of three; seven times more than the General Assistance (GA) grant, and almost three times more than the Supplemental Security Income/State Supplemental Payment (disability) monthly income.[2]

The lack of affordable housing has impacted Alameda County residents, workforce, and consumers and family members in MHSA programs. A number of Full Service Partnership (FSP) providers have reported that lack of affordable housing is a major challenge for many FSP participants.

Alameda County Mental Health Services Utilization

During FY2017/18, Alameda County Behavioral Health Care Services provided behavioral health services to total of 32,605 clients and consumers. Table 2 shows the consumer/client breakdown by age. Adults make up the majority of the consumer population (42%), with Children and Youth being second in numbers of clients in the Alameda County Mental Health System.

Table 2: FY2017/18 Demographics of Consumers – By Age

Age Group	Ages	No. of Consumers	% of Consumers
Children & Youth	0-15	11,247	34%
Transitional Age Youth (TAY)	16-24	5,447	17%
Adults	25-59	13,838	42%
Older Adults	60+	2,073	6%
TOTAL POPULATION		**32,605**	**100%**

[2] Every One Counts! 2017 Alameda County's Homeless Persons Point-In-Time Count.

Table 3: FY2017/18 Alameda County Mental Health Services Penetration Rate by Ethnicity

Ethnic Group	Medi-Cal Beneficiaries	Penetration Rate	Outpatient Penetration Rate	Total Served
Alaska Native or American Indian	1,377	8.86%	5.88%	155
Asian	111,143	1.63%	0.98%	2,422
Black or African American	90,994	8.06%	5.01%	9,054
Hispanic or Latino	125,888	4.92%	4.10%	6,443
Other/Unknown	92,443	4.67%	2.86%	6,247
Pacific Islander	798	6.64%	4.39%	107
White	61,528	6.58%	3.86%	5,941
	484,171			**30,369**

Table 3 shows the mental health services penetration rate by ethnic breakdown. The penetration rate is the percentage of eligible Medi-Cal insured individuals who are utilizing mental health services.

Although Asians make up the highest number of beneficiaries in Alameda County, they have the lowest rate (2%) in accessing mental health services. Native Americans represent the highest penetration rate (8.86%), African Americans have (8.06%), Pacific Islander (6.64%), White (6.58%), Latino (4.92%) in accessing mental health services. Overall, 6% of beneficiaries are accessing mental health services in Alameda County.

A. COMMUNITY SERVICES and SUPPORTS (CSS) PROGRAM SUMMARIES

COMMUNITY SERVICES AND SUPPORTS (CSS) COMPONENT

Mental Health Services Act (MHSA) encompasses five components. The Community Services & Support (CSS) is the largest component, which is focuses on community collaboration, cultural competence, client and family driven services and systems, wellness focus. CSS programs implementation focus on recovery and resilience, integrated service experiences for clients and families, and serving the unserved and underserved. Housing is also a large part of the CSS component.

CSS component funds thirteen Full Service Partnership (FSP) programs and eighteen Outreach Engagement/ System Development (OESD) programs. CSS services include outpatient treatment, crisis response, behavioral health court, co-occurring substance use disorders, integrated behavioral health and primary care, integrated behavioral health and developmental disability services, and in- home outreach**.** CSS programs are implemented through ACBHCS age based systems of care:

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

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

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

<u>CSS Plan Requirements</u>

CSS funded programs must following the following guidelines:

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

A. COMMUNITY SERVICES and SUPPORTS (CSS) PROGRAM SUMMARIES

FULL SERVICE PARTNERSHIP (FSP) PROGRAMS

Full Service Partnership (FSP) Programs

The following measures are adopted by all Full Service Partnership (FSP) programs:

FY 2017/18 FSP Impact Objectives

FSP providers worked with BHCS to develop impact benchmarks in the following areas:

- Improved functioning: Percent of clients with improvement in at least one Adults Needs & Strengths Assessment (ANSA) domain from last assessment to most recent

- Improved living situation: Percent of clients who were living in restrictive and unstable environment at intake who showed an improved living situation at the most recent update

- Primary care connection: Of clients who completed 12 months, percent of clients who were linked to primary care within 12 months of program enrollment (FSP data, Contractor report)

- Reductions in jail days: Of clients who completed 12 months, percent of clients with at least one jail day (FSP data)

- Reductions in psychiatric emergency, inpatient, crisis stabilization utilization: Percent of clients who were admitted in Psychiatric Emergency Service/inpatient/Crisis Stabilization Unit from 12 months prior to current (INSYST)

- Education status: Percent of clients who were not attending school at initial assessment who showed an improvement in status (i.e., enrolled in a vocational program/internship, enrolled in school at least part-time) at the time of most recent assessment (FSP data)

- Employment status: Percent of clients who were unemployed at initial assessment who showed an improvement in their status (i.e., enrolled in a vocational program/internship, found employment, etc.) at the time of most recent assessment (FSP data).

A. COMMUNITY SERVICES and SUPPORTS (CSS) PROGRAM SUMMARIES

FSP 1. Homeless Outreach & Stabilization Team (HOST)
Provider: Bonita House, Inc.

Program Description:
HOST provides FSP services following the ACT Model in northern Alameda County since 2007. Services include personal service coordination (clinical case management), peer support, psychiatric services and medication management, medical services and medication management through partnership with Lifelong, housing support (including emergency housing subsidies, affordable housing search, and coordination with permanent housing providers), Individualized Placement Support (IPS) vocational services linking to school and work, psychoeducational groups, individual therapy and drop-in services.

Target Population:
Adults experiencing chronic homelessness and severe and persistent mental illness.

FY17/18 Program Outcomes

Unduplicated Number of Partners Served: 84

GOALS	Clients who met Goals
50% Decrease in Hospital Days	80%
50% Decrease in Hospital Admits	80%
50% Decrease in Psychiatric Emergency Services (PES)	88%
Linked to primary care within 12 months of program enrollment	100%
Partners with Stable Housing	6%

FY 2017/18 Impact

Many partners state “this program saved my life.” Historically having the ability to provide permanent housing for partners experiencing homelessness provided a foundation from which individuals could make progress in their recovery. The program supports people in getting off the streets, getting benefits such as insurance and social security, becoming psychiatrically stable, reducing interactions with the criminal justice system and emergency services, improving overall physical health to reduce acute medical care, and integrating into the community as employees, students, volunteers, and advocates.

Partner’s Story

An upcoming graduate of the program enrolled following 10 years of homelessness, repeated lethal suicide attempts, and extremely unstable behavior and relationships. Though she lost housing with the program several times, the Housing First model allowed her to continue with a baseline level of stabilization while she worked with the psychiatric and personal service coordination team to address her mental health symptoms. Though she continued to have bouts of significant suicide ideation over the years she began learning and using coping skills to manage it, and eventually ceased self-harm altogether by substitution the impulse with art and exercise. With the aid of Medication Assisted Treatment (MAT), she became sober following a long history of IV heroin use, and with encouragement

and linkages from the team became a very involved volunteer at the needle exchange and facilitated a weekly Dual-Recovery Anonymous meeting. She is currently anticipation graduation in the next couple of months and is in the process of opening alternative addiction treatment services to give back to the community.

FY 2017/18 Challenges

One significant barrier over the past fiscal year has been the transfer of permanent housing monies to another organization. Due to this change, the team has had less control over the housing outcomes for our partners who were not already housed at the time the switch occurred. One example is a partner who came up on a below-market rate waitlist they had applied for years before and was unable to take advantage of the opportunity due to being unable to afford the rent entirely on their own and HOST being unable to cover the difference.

Another barrier has been significant staff turn-over caused in part due to the high burnout nature of the work, but also importantly due to rising cost of living in the area and the inability for the program to increase salaries proportionately. Several high functioning team members left this year due to extremely long commute times (some driving 2 hours each way) which are a product of them being unable to afford to house their families in the area. The increased cost of living has also stretched the emergency housing budget very thin, with 21 day hotel placements going up to $1,800 as rents in the area continue to increase with no proportional increase in housing budget. As a result, fewer partners are able to stay in emergency housing with program funds and the Housing First Model is unable to be adhered to with high fidelity.

A. COMMUNITY SERVICES and SUPPORTS (CSS) PROGRAM SUMMARIES

FSP 2. North County Senior Homeless Program (NCSHP)
Provider: Bay Area Community Services (BACS)

Program Description:
Assertive Community Treatment (ACT) model infuses a wraparound philosophy to transform lives for older adults who are homeless or housing insecure, have a moderate to severe and persistent mental illness and comorbidities including active substance use, physical health/chronic conditions, and issues related to poverty and generational trauma. Services including around the clock crisis intervention, counseling and therapeutic support, intentional clinical case management, medical case management and nursing, medication support, housing navigation, substance use counseling, and holistic engagement of natural community supports for community integration.

Target Population:
Older adults who are homeless or housing insecure and have a severe and persistent mental illness and co-occurring substance use and physical health conditions who qualify for the highest level of community-based care outside of an institutional setting.

FY 2017/18 Program Outcomes

Unduplicated Number of Partners Served: 46

GOALS	Clients who met Goals
50% Decrease in Hospital Days	82%
50% Decrease in Hospital Admits	82%
50% Decrease in Psychiatric Emergency Services (PES)	80%
Linked to primary care within 12 months of program enrollment.	100%
Partners with Stable Housing	35%

FY 2017/18 Impact

The NCSHP benchmarks for FY17/18 were surpassed, with intended impact on individuals and the system as a whole reached. 1 out of 5 partners entering the program during this period entered without benefits. This partner was connected to advocacy through Homeless Action Center, began receiving General Assistance then SSI.

FY 2017/18 Challenges

The program's main challenges include supporting individuals in a traditional format that does not rely on institutional or traditional approaches to public behavioral health systems. So many of our partners have been institutionalized and are accustomed to programs that are oriented to 'case management' when in fact, the FSP is oriented to transforming lives through innovative clinical and pragmatic approaches so that there is a different and more positive outcome. Keeping the transformative orientation and philosophy at the center of the partner when the partner has had long time negative

experiences with the system is challenging. The NCSHP team continues to build transformative and restorative practices to ensure the FSP does not ever morph in to just another 'case management' function for the County and partners served. To this end, BACS FSP is focused on a goal of family finding and unification which is untraditional in the adult and older adult system of care. In the next reporting period, the FSP will have a goal of working towards partner driven team decision making meetings (TDMS) that aim to include at least 51% of natural supports (not professionals).

A. COMMUNITY SERVICES and SUPPORTS (CSS) PROGRAM SUMMARIES

FSP 3. Supportive Housing for TAY (STAY)
Provider: Fred Finch Youth Services

Program Description:
STAY provides clinical case management, crisis intervention, individual rehab, peer mentoring, medication management, IPS employment support, housing assistance, collateral support for families, and skill building and socialization groups.

Target Population:
The STAY Program is located in Oakland and serves Transition Age Youth participants (ages 18 to 24) with serious mental health conditions throughout Alameda County.

FY 2017/18 Program Outcomes

Unduplicated Number of Partners Served: 42

GOALS	Clients who met Goals
50% Decrease in Hospital Days	41%
50% Decrease in Hospital Admits	47%
50% Decrease in Psychiatric Emergency Services (PES)	53%
Linked to primary care within 12 months of program enrollment	80%
Partners with Stable Housing	36%

FY 2017/18 Impact

Partner's Story:

One STAY participant who particularly benefited from STAY services during the past year is a 22 year-old African-American man who was admitted to the program during a period of psychiatric instability and homelessness. In the months leading up to his admission and in the weeks just afterwards, he had two inpatient admissions, two crisis residential stays, and mulitple contacts with psychiatric emergency services as he struggle with paranoia, aggitation and cognitive disorganization. His STAY Personal Services Coordinator (PSC) worked to engage him and to establish trust by providing support with immediate needs and serving as a consistent, empathic presence. With his consent, the PSC collaborated with the participant's mother to keep track of his whereabouts and to help him access needed emergency services and shelter. The participant began working with the STAY Nurse Practitioner who convinced him to try an injectable antipsychotic. The medication significantly stabilized the participant's psychotic symptoms, and reduced his aggitation. The PSC helped the Partner get stable housing at group residence serving transitional-age youth at about the same time. Within a matter of a couple of weeks, the Partner's functioning dramatically improved. He began attending program skills groups, working with the STAY Employment Specialist to get a job, and cutting down on his Cannabis intake. His mother said she hadn't seen him doing this well in over a year.

FY 2017/18 Challenges

The STAY Program has been challenged most by the housing crisis in county. Spaces at all levels of the housing service system are more limited including shelters, transitional housing, board and care facilities and subsidy programs. Far fewer opportunities exist for supporting participants in independent living in their own apartments now that housing subsidies have been removed from their previous coupling with FSP Programs and housing on the open market is prohibitively expensive. At the same time, the cost of living in the area and the plethora of social services jobs available has made hiring and retaining staff challenging. The program has spent the entire year short staffed in one position or other, or multiple ones at that same time. This impacts our ability to provide the needed service levels for our program participants.

A. COMMUNITY SERVICES and SUPPORTS (CSS) PROGRAM SUMMARIES

FSP 4. Greater HOPE
Provider: Abode Services

Program Description: Greater HOPE FSP is a comprehensive community based treatment program serving adults who have been diagnosed with serious mental illness and co-occurring disorders, utilizing the Assertive Community Treatment (ACT) model. Participants receive services from a multi-disciplinary mobile mental health team providing: intensive case management, harm reduction strategies, employment and psychiatric services, crisis intervention, as well as housing navigation and stabilization support. The Greater HOPE FSP serves all of Alameda County and is housed in Hayward.

Target Population:
Adults and older adults who are chronically homeless.

FY 2017/18 Program Outcomes

Unduplicated Number of Partners Served: 76

GOALS	Clients who met Goals
50% Decrease in Hospital Days	75%
50% Decrease in Hospital Admits	75%
50% Decrease in Psychiatric Emergency Services (PES)	79%
Primary Care linkage within 12 months of program enrollment	100%
Partners with Stable Housing	93%

FY 2017/18 Impact

Greater HOPE provides extensive wrap around support to 76 participants at present. We have supported participants with a 93% retention rate for housing.

Partner's Story:

The FSP team has helped a participant remain housed for the past year who was referred to Abode from a Service Team and had left her two previous housing placements due to the severity of her symptoms of Schizophrenia. At the time of referral, she reported that she wanted to leave housing. With continued wrap around support, she has been able to maintain her unit and seek out support when feeling overwhelmed. Services consisted of frequent psychiatric, therapy, case management, employment, outreach and group engagement. The FSP team also supported a 34 year old female participant diagnosed with Schizophrenia, PTSD and Stimulant Abuse who has been enrolled for the past 4 years. Her team provided 1-2 times weekly individual therapy to process her history of trauma, 2-3 times weekly brokerage/case management services to support on legal, financial, employment and educational goals. Once a week, medication management and psychiatric counseling was provided to support the client in managing her symptoms of psychosis and depression. 1-2 times monthly collateral support was provided with friends and her mother. She is also connected to the Peer Specialist participating in the WRAP group and Peer led committee. This participant has been clean and sober for 8 months. She has completed one full round of WRAP groups, and is now co-facilitating the committee.

She signed up for services with the Department of Rehabilitation and is working with our IPS Employment Specialist to secure employment. She has maintained her daily routine for the past 8 months, has attended over 80 AA meetings in the last 3 months, maintained housing for the past 3 months and is working towards independent living. She recently shared that she now knows what her diagnosis is, that recovery is real and can articulate what her triggers are to relapse and is looking forward to getting her own place soon and going back to work.

FY 2017/18 Challenges

There was an influx of referrals during Quarter 3 and 4 which led to the need to triage support and think creatively about service delivery in order to provide quality care to incoming and existing participants. This created a culture shift for staff that took time to transition into. Also, there has been a few participants who are preparing for graduation and are struggling with the transition as they have received care within the FSP program for several years. Staff is working to support their transitions to service teams or outpatient therapy and psychiatry.

A. COMMUNITY SERVICES and SUPPORTS (CSS) PROGRAM SUMMARIES

FSP 5. Forensic Assertive Community Treatment Program (FACT)

Provider: East Bay Community Recovery Project (EBCRP)

Program Description:

Forensic Assertive Community Treatment (FACT) is a Full-Service Partnership (FSP) program of the East Bay Community Recovery Project that provides forensic mental health services and maintain an active caseload of 76-79 adult participants ages 18 and older. 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, inpatient services, and Santa Rita jail. The program provides these intensive level to encourage decreased symptomatology and increase in their ability to function more independently in the community. Improving their lives while significantly reducing or eliminating their need for incarceration, psychiatric emergency, and inpatient services.

Target Population:

Forensic involved mentally ill and often co-occurring substance using adult individuals age 18+. Most partners fall in the 26-34 age group and they are frequently incarcerated—charged with crimes that are believed to have been a partner's behavioral response to internal mental health symptoms or an attempt to meet survival needs through theft. Partners also over utilize psychiatric emergency and inpatient services for mental health stabilization. Partners' unique needs include advocacy and support with the court process (prosecuting and defense attorneys, the judges in Alameda County Court Rooms) and the jails for community re-entry coordination.

FY17/18 Program Outcomes

Unduplicated Number of Partners Served: 75

GOALS	Clients who met Goals
50% Decrease in Hospital Days	65%
50% Decrease in Hospital Admits	61%
50% Decrease in in Psychiatric Emergency Services (PES)	52%
Primary Care linkage within 12 months of program enrollment	100%
Partners with Stable Housing	38%

FY 2017/18 Impact

The primary positive impact is the partner's decrease in symptomatology, increase in functioning, and subsequent increase in the quality of their lives. One important measure of this positive impact is the reduction and or elimination of partner's time spent in jails, psychiatric emergency and inpatient hospitals and increasing their time in treatment in the community.

A. COMMUNITY SERVICES and SUPPORTS (CSS) PROGRAM SUMMARIES

The partner's improvement in functioning and ability to participate in interpersonal relationships is a positive outcome of the program and their treatment in the community. This is important as in many cases a partner's desire to see and be with their families can often be one of the motivating factors for them to work their recovery program and to achieve wellness. Supporting partners to become integrated into the community through work, education, volunteerism and independent living along with bringing families back together are positive steps towards strengthening communities. By getting involved and participating in their communities, partners are giving back and contributing to the community's health and prosperity.

FY 2017/18 Challenges

Staffing: Program has been severely understaffed this reporting period by having several open positions for several months. Staff have had to take on more responsibilities as positions were vacated which has been a hardship for the entire staff. The positions have been posted for months and only now there have been some promising candidates. The goal, with current candidates, is to fill two Personal Service Coordinator positions in July.

Access to co-occurring residential treatment beds: 91% of the Partners experience mental health and co-occurring substance use challenges. As a primary mental health community- based program, co-occurring residential treatment programs have been an important resource. The County has only a handful of these programs currently and they have long waiting lists.

Transition of Housing Management and Landlord Services and its impact on housing services for FACT program participants: Due to a federal mandate for counties to develop a housing Coordinated Entry System (CES), the programs housing funds were taken and pooled with other county housing funds to support this initiative. Moving forward our primary concern is "time" and how long the new process will take to complete the referral application for housing to the actual placement of a partner in a subsidized apartment. Now that there is a waiting list for the entire county for subsidized housing, it is anticipated there may be a much longer process to getting participants housed. Behavioral Health Care Services, the Housing Services Office Director, and the Adult System of Care Director, and the Behavioral Health Court colleagues have been informed that this new housing process will impede our ability to house both FACT in a timely manner. We are clear about these new challenges for the timely housing of participants and that we are going to make every effort to make these housing referrals much sooner in the participant's program enrollment to allow for our new housing service providers to have the time to locate and subsidize units for the participants.

Partner's Story

A Partner first encountered the FACT team when staff outreached to him while he was in jail. Prior to then the Partner struggled with a decade's long cycle of brief incarcerations for community offenses such as possession of open containers in public, petty theft, and publicly exposing himself. He had been homeless for 20 years. His mental health had begun to decline and his drinking increase after his mother passed away. He was diagnosed with schizophrenia, was haunted by voices and struggled with alcohol use. He was often seen to be verbally inappropriate toward people on the street, which led to numerous conflicts with local merchants when he became threatening and violent. The FACT team spent a long time outreaching to him in order to engage him in treatment. Although he initially expressed ambivalence to housing, but he eventually agreed to move into the transitional housing. Once living onsite, he began participating in the dual disorder day treatment program. In his new environments, he was challenged socially by interpersonal relationships while working on himself to develop and maintain appropriate personal boundaries to have healthier relationships. After some time, he agreed to take

medication through injection to help him manage his mental health symptoms. Fortunately, his first medication regimen worked well and his symptoms began to dissipate. The FACT staff worked with the Partner through a harm reduction model in his alcohol use and began to slowly encourage him to focus on his health (diabetes) and to reduce his drinking. Once he was able to manage his symptoms (medication and sobriety) he started to care more about his health and developing social supports so that he did not self-medicate with alcohol as much. After about six months living in FACT Transitional Housing, he was approved for his own subsidized apartment. He continued to attend the day treatment program 3 days a week where he had become a kind of elder to the group while acting as a mentor to newcomers. There, he rediscovered a nurturing side of himself that really enjoyed helping people. He lived successfully and paid his rent and utilities on time. He made serious changes in his life. He not only improved his life, he improved the lives of others as he recovered. This partner narrative demonstrates that it may take a very long time to engage clients to get them to accept the help we think they need. However, patience, persistence and meeting them where they are can definitely pay-off.

A. COMMUNITY SERVICES and SUPPORTS (CSS) PROGRAM SUMMARIES

FSP 6. Transition to Independence Program (TIP)

Provider: Berkeley Mental Health

Program Description:
Full Service Partnership (FSP) program that encompasses clinical support, case management, medication management, and peer supports.

Target Population:
Transitional Aged Youth (TAY) ages 16-24 who suffer from severe mental illness and have Alameda County Medi-Cal.

FY 2017/18 Program Outcomes

Unduplicated Number of Partners Served: 27

GOALS	Clients who met Goals
50% Decrease in Hospital Days	50%
50% Decrease in Hospital Admits	50%
50% Decrease in Psychiatric Emergency Services (PES)	67%
Primary Care linkage within 12 months of program enrollment	4%
Partners with Stable Housing	100%

FY 2017/18 Impact
The program impact on most of the clients served has been positive and has significantly changed their lives. Over half of the clients are being transitioned to lower levels of care, as their successes in treatment have been sustained.

Partners' Stories
One client, in particular, has had major gains. When he started the program, his mental health issues severely limited his ability to attend high school, to leave his home to make short visits in the community, or even to leave his room. Staff was able to work diligently with him and were able to get him to school on a part-time bases, then full time. The psychiatrist worked with the family to provide education about medication and management. The client has graduated from high school, and has completed his first year of college. He is pursuing a career in computer engineering.

Another Partner's story is a client who started with the program with a severe co-occurring disorder. She had not been able to successfully attend a SUD program for more than 1 day, once she stayed for 4 days. She had multiple hospitalizations, a few incarcerations, and has had multiple long term stays at Villa Fairmont. Today, she is a successful graduate of a residential SUD program, has participated in a healthy eating and cooking program, and is currently completing an employment training program.

FY 2017/18 Challenges

A. COMMUNITY SERVICES and SUPPORTS (CSS) PROGRAM SUMMARIES

There have been two factors that have been large barriers to successful program implementation. The use and abuse of substances such as methamphetamines and opioids has been major challenging factor that has impacted the ability to provide services and for client to sustain any gains made. The second factor, has been the housing crisis. The TAY-TIP population is profoundly impacted by a lack of housing specific to those with SMI and protracted histories of trauma and abuse. A third barrier, although less significant of an impact, has been some staffing issues complicated by the cost of living factors in the Bay Area. The staffing has been stable for the past 5 months. However, in the recent past it took some time to secure staff who could commit to temporary employment to fill vacant positions following a retirement and a staff person who chose to further her education.

A. COMMUNITY SERVICES and SUPPORTS (CSS) PROGRAM SUMMARIES

FSP 9. Transitional Assertive Community Treatment Program
Provider: East Bay Community Recovery Project

Program Description:
TrACT is a Full-Service Partnership (FSP) of the East Bay Community Recovery Project and is the dedicated service provider for the Alameda County Behavioral Health Court. TrACT provides services to and maintain an active caseload of 29 partners. This court-supervised program is for adult individuals with severe mental illness 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. The partner's 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.

Target Population:
- The referred individual is 18 – 59 years old and a resident of Alameda County
- Having a current legal case in Alameda County Superior Court
- Having that case referred to Behavioral Health Court for screening
- Having a mental health condition that is severe in nature and persistent in duration
- A mental health condition with symptomatology present during the commission of the crime
- The individual has or is eligible for Medi-Cal insurance

Unduplicated Number of Partners Served: 70

Graduates transitioned to a lower level of care: 19

GOALS	Clients who met Goals
50% Decrease in Hospital Days	71%
50% Decrease in Hospital Admits	73%
50% Decrease in Psychiatric Emergency Services (PES)	65%
Primary Care linkage within 12 months of program enrollment	83%
Partners with Stable Housing	27%

Program Impact FY 2017/18
The primary positive impact is the partner's decrease in symptomatology, increase in functioning, and subsequent increase in the quality of their lives. One important measure of this positive impact is the reduction and or elimination of partner's time spent in jails, psychiatric emergency and inpatient hospitals and increasing their time in treatment in the community.

The reunification of partners with their family and loved ones is part of the healing/recovery process. This reunification process is more common in the TrACT program most likely due the high number of younger participants in the court program. The partner's improvement in functioning and ability to participate in interpersonal relationships is a positive outcome of the program and their treatment in

the community. This is important as in many cases a partner's desire to reconnect and be with their families can often be one of the motivating factors for them to achieve wellness by working their recovery program and. Supporting partners to become integrated into the community through work, education, volunteerism and independent living along with bringing families back together are positive steps towards strengthening communities. By getting involved and participating in their communities, partners are giving back and contributing to community's health and prosperity.

Program Challenges FY 2017/18

Staffing: We have been severely understaffed this reporting period by having several open positions for several months. Staff have had to take on more responsibilities as positions were vacated which has been a hardship for the entire staff. The positions have been posted for months and we are only now starting to get some promising candidates. The goal is to fill two Personal Service Coordinator positions in July.

Access to co-occurring residential treatment beds: It has been determined that 91% of our partner's experience mental health and co-occurring substance use challenges. As a primary mental health community-based program we are always looking for co-occurring residential treatment programs. The county has only a handful of these programs currently and they have long waiting lists.

Transition of Housing Management and Landlord Services: Due to a federal mandate for counties to develop a housing Coordinated Entry System (CES), the programs housing funds were taken and pooled with other county housing funds to support this initiative. Moving forward our primary concern is "time" and how long the new process will take to complete the referral application for housing to the actual placement of a partner in a subsidized apartment. Now that there is a waiting list for the entire county for subsidized housing we anticipate a much longer process to getting participants housed. The TrACT program has already begun to experience delays in housing and stepping down graduates to a lower level of care due to this transition of housing management and landlord services to another agency and the funds to the County CES.

Finally, we have informed Behavioral Health Care Services—our county contract monitor, the Housing Services Office Director, and the Adult System of Care Director—and our Behavioral Health Court colleagues that this new housing process will impede our ability to house both FACT and TrACT partners in a timely manner. We are clear about these new challenges for the timely housing of participants and that we are going to make every effort to make these housing referrals much sooner in the participant's program enrollment to allow for our new housing service providers to have the time to locate and subsidize units for the participants.

Partner's Story (as told in her own words)

Partner was born in the Bay Area to a family of mentally ill addicts and codependents. When she was 18 months old, her mother beat her for the first time for coloring on the wall. Her mother was still nursing her, but that day she went to the corner of the room, sat down, and started sucking her thumb thus weaning herself. At only 18 months old, Lucia's trust in people was severed. Her mother took her to the doctor groaning about her soar breasts to try to find out what was the matter with Lucia. Lucia was

beaten and gas lighted by her mother, her connection to trust in herself and the outside word, starting at just 18 months old.

In the summer of 2009, Partner became the third partner, and first female partner of the TrACT Program. She was in Santa Rita at the time. Having been working at a Starbucks where the assistant manager sexually harassed her, she became so stressed out that her family predisposition to the mental chemical imbalance of bi-polar disorder was set in motion and she became like a butterfly with one wing who can't fly and spirals downward. She was fired in the spring of 2009 and by summer she had attacked her older sister with pepper spray and was arrested and sent to Santa Rita. She was so bad off the first week at Santa Rita that she was locked up in solitary confinement. She was then transported to the mental health floor in Santa Clara County Jail where Alameda County pays for 4 beds. She got one bed of four for mental health treatment for the entire county of Alameda. When she returned to Alameda County after three weeks after being put on meds, she found out she had been referred to the TrACT Program through Behavioral Health Court. She was accepted to the program from jail, and was finally released after a long jail term. She lived at Bonita House Treatment Facility for Co-Occurring disorders for over a year, lived a bit in Bonita House satellite SILs, then found HUD subsidized housing. She was taken off probation after two years, one year early, and her record was expunged.

Today the Partner is an English Major and writes short stories, screenplays, poetry, and even does stand-up comedy. She enjoys doing 5K fun runs, walking her Chihuahua, playing with her cat, and cooking. She has not been back to jail or had any run-ins with the law in 8 years. She enjoys going to twelve step meetings and recovery retreats and she takes her meds every day. If there is one thing she has learned from being a participant in Behavioral Health Court, TrACT and EBCRP, is that participant is the key word. You need to participate in your recovery to get anything out of it. She learned this in TrACT and applies it to her everyday life. She knows the more she participates in school and work, hobbies and activities, friends and family, her ongoing recover, and life in general, the more she pulls herself out of the hell of where her mind took her. She will always be grateful to TrACT and EBCRP, not for saving her life, but for encouraging her to save her own live. And for this she gives thanks.

A. COMMUNITY SERVICES and SUPPORTS (CSS) PROGRAM SUMMARIES

FSP 10. Housing Services

Provider: Alameda County Behavioral Health Care Services Housing Services Office

Program Description:

The Alameda County Behavioral Health Care Services Housing Services Office (HSO) coordinates a range of housing programs and services for individuals struggling with serious mental illness. Core goals include:

1. Increase the availability of a range of affordable housing options with appropriate supportive services so that individuals with serious mental illness 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

Housing Services Office (HSO) Programs:

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

Target Population:

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

A. COMMUNITY SERVICES and SUPPORTS (CSS) PROGRAM SUMMARIES

FY 2017/18 Program Outcomes

1. Number of consumers served: Reached at least 1,500 people with serious mental illness
2. Number of activities or services utilized:
   - More than 450 households received long-term housing financial assistance and supportive services to keep their housing;
   - 128 households received short-term housing financial assistance;
   - 120+ stayed in MHSA-funded temporary housing;
   - 400+ received housing-related services including outreach, navigation, or permanent supportive housing services.
3. Retention Rates:
   - 85% housing retention rates
   - 35% temporary housing exits to permanent housing

FY 2017/18 Impact

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

Over the past 12 months, the BHCS Housing Services Office has deepened its partnership with the Alameda County Care Connect (www.accareconnect.org) Medi-Cal waiver program allowing for a significant expansion of housing-related resources for BHCS consumers, family members, and providers. This partnership has expanded outreach to homeless persons, housing navigation services to help individuals move from homelessness back into permanent housing, and support services to expand permanent supportive housing capacity in the County. Bay Area Legal Aid now provides more extensive housing-related legal assistance through phone consultations, educational workshops, and representation of clients in individual cases. The Alameda County Independent Living Association (www.alamedacountyila.org) launched to expand the number of high-quality independent living/room and board operations within the County. Over the past year, the HSO worked to consolidate MHSA housing subsidy funding in a central pool to allow for broader access to these subsidies and to decouple long-term housing subsidies from enrollment in specific service programs. HSO continues to work to support and improve Alameda County's Housing Crisis Response and Coordinated Entry System to make it as effective as possible in preventing and ending homelessness.

FY 2017/18 Challenges

The most significant challenge facing the Housing Services Office is the rapidly rising costs of housing within the County. More specifically, there have been significant declines in the number of licensed board and care and room and board beds for people with serious mental illness. Individuals approved for long-term rental assistance funded by MHSA, Housing and Urban Development (HUD), or other dollars face significant barriers in trying to find private property owners willing to rent housing units to them. Over the past year, Alameda County has begun implementation of a Housing Crisis Response and Coordinated Entry System as required by HUD. The roll-out of this new approach to helping individuals experiencing homelessness has included shifts to a new data system, a new standardized assessment for accessing resources, and a range of new programs and providers. Challenges with new system implementation, hiring of key staff positions, and cross-jurisdictional and cross-agency coordination

challenges, have resulted in delays and frustrations for providers and clients seeking assistance. Improvements in the system are expected over time but these improvements are limited by the availability of long-term resources to support the operations of temporary and permanent housing resources. Additional housing and homelessness-related investments from county, state, and private funding will be coming over the next fiscal year.

A. COMMUNITY SERVICES and SUPPORTS (CSS) PROGRAM SUMMARIES

FSP 11. Community Conservatorship (CC) Program

Provider: Telecare

Program Description:
Telecare CC staff will support individuals on their journey in healing and provide a full range of services, including medical and psychiatric services, case management services, advocacy and linkage, referral to safe and affordable housing, substance use interventions and counseling, assistance with entitlements, support and education with family and significant others, connection with community resources and self-help groups.

Target Population:
Individuals diagnosed with severe mental illness, many of whom would otherwise require extended care in institutional settings. This includes individuals who are high utilizers of mental health services and who are considered to be at great risk for psychiatric hospitalization. Referrals come directly from psychiatric hospitals and focus on individuals who are voluntarily willing to participate in ongoing mental health treatment and short-term Conservatorship as a way to help them transition back to community settings with support of a treatment team, conservator, and court supervision.

FY 2017/18 Program Outcomes

Unduplicated Number of Partners Served: 14

GOALS	Clients who met Goals
Partners with Stable Housing	100%

FY 2017/18 Impact
The CC Team collaborates with the Public Guardian's Office to support individual clients to sustain the least restrictive placements within the community. The intensive services provided as one program have both amplified positive contributions to the community- including competitive employment- and increased trust between clients, family members, and service providers.

Partner's Story
A partner with an extensive history of acute and sub-acute hospitalizations involving issues residing in the family home recently obtained a driver's license and has been working for more than a month to earn extra spending money. The family is ready to support this client's move home again in the near future.

FY 2017/18 Challenges
- Availability of supervised housing placements in the Bay Area
- Common systemic issues associated with all case management programs in Alameda County, such as housing costs and crisis-residential bed availability
- Improving communication between agencies

A. COMMUNITY SERVICES and SUPPORTS (CSS) PROGRAM SUMMARIES

FSP 12. Assisted Outpatient Treatment (AOT)
Provider: Telecare

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

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

FY 2017/18 Program Outcomes

Unduplicated Number of Partners Served: 15

FY 2017/18 Impact

The AOT program has supported individual clients with the frequency and flexibility of ACT model, wrap-around services necessary to increase participation in behavioral health treatment and maintain stable housing placement in the community. This has, in turn, enhanced the client's sense of safety and stability as well as increased their capacity to pursue their health, hopes, and dreams. The support of the AOT program has contributed to improving family relationships as well as reducing contacts with law enforcement and psychiatric crisis services, improving the overall safety of the individual client, the family, and the community.

Partner's story: A previously homeless client who struggled with adhering to his psych meds regimen as prescribed has been successfully residing in an independent living facility for over one month and recently began receiving a long-acting injectable medication. This client also experienced frequent hospitalizations following altercations with family members in the past, but in the last month has experienced improved family communication.

FY 2017/18 Challenges

- Difficulty finding and serving clients within notice of hearing 5 day window allotted by statute.
- Difficulty finding clients after initial court appearances
- Engagement barriers inherent to the AOT model (court-ordered treatment)
- Common systemic issues associated with all case management programs in Alameda County, such as housing costs and crisis-residential bed availability.

A. COMMUNITY SERVICES and SUPPORTS (CSS) PROGRAM SUMMARIES

FSP 13. CHANGES
Provider: Telecare

Program Description:
The CHANGES FSP provides integrated substance use and mental health services. All services are delivered using the Assertive Community Treatment (ACT) service delivery model. Services offered include assessment, housing referral and support, payeeship and money management, individual psychotherapy, individual and group rehabilitation, medication management, healthcare screening, family psychoeducation, substance abuse counseling, and employment support in the form of Individual Placement and Support (IPS).

Target Population:
Adults with serious mental illness (SMI) and Co-Occurring Substance Use Disorders

FY 2017/18 Program Outcomes

Unduplicated Number of Partners Served: 62

GOALS	Clients who met Goals
50% Decrease in Hospital Days	67%
50% Decrease Hospital Admits	65%
50% Decrease in Psychiatric Emergency Services (PES)	50%
Primary Care linkage within 12 months of program enrollment	46%
Partners with Stable Housing	70%

FY 2017/18 Impact

As a direct result of the integrated, individualized client-driven services and supports provided by the CHANGES FSP, many FSP clients experienced improvements in the quality of their lives through increased income, better access to housing and healthcare, and improved mental health wellness due to better self-management of their psychiatric condition.

Partner's Story
The outcomes experienced by Client BB exemplify the impact of the CHANGES FSP's "whatever it takes" approach to services. Client BB struggled with frequent John George Psychiatric Pavillion (JGPP) visits, jail stays, and had been homeless or transient for over 5 years, never staying in one board and care for more than 2 months. She was often kicked out of placements for breaking windows, fights with roommates, destruction of property. CHANGES FSP team members worked tirelessly to create a collaborative partnership with BB, determining her needs and her readiness to change, coordinating services and supports with housing staff at county and community levels, coaching the client in emotional self-management techniques, and teaching her how to manage her own medications. Staff even supported the client's efforts to work through emotional regulation issues by providing her with art supplies to manage mood swings, something she had identified she wanted to try doing. Client BB

has now been successfully housed for 10 consecutive months, her longest housing tenure in over 5 years. Now that she has achieved greater stability, she has also been able to reconnect with her father. This is a huge plus for her social support.

FY 2017/18 Challenges

CHANGES FSP encountered two main obstacles to program implementation.

1. An increasing number of referrals either refused services, and/or were homeless and were referred with no contact information, including no phone number. The lack of contact information made effective outreach to these new referrals very difficult. Further complicating successful referral was the reduced frequency of warm handoffs in the referral process. Another barrier to successful engagement was the lack of funding for outreach and engagement activities. Finally, CHANGES staff also experienced challenges establishing effective collaborations with IHOT teams.

2. As in prior years, maintaining full team staffing was an ongoing challenge. Between July 2017 and June 2018, the Changes FSP team experienced an 83% turn-over rate. As a result, team continuity and staffing capacity were also impacted. All of the positions were eventually filled, however the length of time it took to recruit, hire, and train new staff limited the program's ability to meet performance benchmarks.

A. COMMUNITY SERVICES and SUPPORTS (CSS) PROGRAM SUMMARIES

FSP 14. STRIDES
Provider: Telecare

Program Description**:**
Telecare STRIDES is in downtown Oakland and serves individuals living within the boundaries of Alameda County. STRIDES follows Telecare's integrative Recovery-Centered Clinical System (RCCS), an innovative recovery framework that incorporates the latest research and evidence-based practices. STRIDES, through the RCCS model, strives to create an environment that supports recovery. RCCS emphasizes doing no harm and supporting and enlivening recovery.

STRIDES utilizes Recovery Model in its approach to client care. This model incorporates elements of Motivational Interviewing, Seeking Safety, Cognitive Behavioral Therapy, Dialectical Behavioral Therapy (DBT), Strengths-Based Case Management, Trauma-Informed Care, Harm Reduction, and other client-centered therapeutic interventions.

All services are provided with the goal of enhancing an individual's safety, health, and quality of life. These services include- but are not limited to- medication and symptom management, coordination of health care, money management, increasing social supports, supportive counseling, family connection, Crisis Response, Family Support Groups, Member Advisory Council, addressing internalized stigma and the effects of trauma, psychosocial assessment, individualized and collaborative treatment planning, Co-Occurring Education Groups, 24-7 On-Call availability, as well as independent living skills training.

Target Population:
STRIDES of Alameda County is a voluntary, ACT-model, community-based outpatient treatment program for Adults with complex behavioral health needs and diagnoses of Severe Mental Illness (SMI), including Schizophrenia, Schizoaffective Disorder, as well as Bipolar I Disorder and Bipolar II Disorder. Many of these individuals would otherwise require extended care in institutional settings. STRIDES serves individuals who are high utilizers of mental health services and who are at great risk for psychiatric hospitalization and criminal justice involvement. A small percentage of these individuals are homeless. Individuals accepted into STRIDES must have Alameda County Medi-Cal or be Medi-Cal eligible.

FY 217/18 Program Outcomes

Unduplicated Number of Partners Served: 138

GOALS	Clients who met Goals
50% Decrease in Hospital Days	64%
50% Decrease Hospital Admits	58%
50% Decrease in Psychiatric Emergency Services (PES)	45%
Primary Care linkage within 12 months of program enrollment	100%
Partners with Stable Housing	82%

FY 2017/18 Impact

STRIDES provides adults diagnosed with severe mental illness with the frequency, flexibility, and versatility of recovery-centered, ACT model outpatient services. By utilizing the RCCS model, STRIDES staff engage individual clients to evoke their internal motivation to increase participation in mental health treatment and the journey of recovery. STRIDES' 24/7 On-Call, crisis response, and wrap-around services support individuals to maintain stable housing placement in the community, reducing homelessness and social isolation as well as the negative health and wellness outcomes associated with these conditions. STRIDES' multi-disciplinary, community-based approach increases access to integrative medical and psychiatric care, improving the overall health of the individual client. The support provided for family members of individual clients through Family Support Groups are aimed at easing the burden of care and improving family dynamics. Each of these aspects enhance the individual client's sense of well-being as well as increase the client's capacity to pursue their health, hopes, and dreams. As a result, STRIDES services reduce contacts with law enforcement and psychiatric crisis services, enhancing the overall safety and well-being of the individual client, the family, and the community.

Partner's Story

An individual client with a limited work history and an extensive history of justice involvement as well as acute and sub-acute hospitalizations obtained competitive, part-time employment several months ago with support of the STRIDES IPS Vocational Specialist and still loves their job. Employment has reduced the distress associated with their psychiatric symptoms as well as increased their housing stability, and as such they are approaching graduation from STRIDES to a lower level of care.

FY 2017/18 Challenges

Challenges and barriers for STRIDES program implementation include- but are not limited to- need of more affordable, high-quality, supportive and independent housing in Alameda County; need of more inpatient, sub-acute, dual-diagnosis/substance use residential rehabilitation program, and crisis residential program beds; need for improved inter-agency collaboration and communication, including the criminal justice system and county crisis services; and need for more day-treatment programs and funding to support client competitive and supportive employment as well as education endeavors.

A. COMMUNITY SERVICES and SUPPORTS (CSS) PROGRAM SUMMARIES

FSP 15. STAGES
Provider: Telecare

Program Description:
STAGES is an Older Adult FSP that serves up to 46 partners with complex needs. Our office is in downtown Oakland, but the majority of our services are provided in the community throughout Alameda County.

This team is comprised of a psychiatric physician assistant, registered nurse, licensed clinical social worker, team leader and personal service coordinators. We have a high staff to partner ratio and we have staff availability 24-hours/seven days a week. The staff assists partners in obtaining a full-range of services, including; mental health care, medical support, medication education, 24-hour crisis response, case management, substance use services, trauma informed services, housing access, assistance with entitlements, support and education of family and significant others, assistance with increasing social support networks and connecting with meaningful community activity.

Target Population:
All of our partners are aged 58 and older and have a diagnosis of serious mental illness. They all are able to live in a community setting with STAGES support. Some have co-occurring substance use disorders and most have co-occurring health needs.

FY 2017/18 Program Outcomes

Unduplicated Number of Partners Served: 56

GOALS	Clients who met Goals
50% Decrease in Hospital Days	78%
50% Decrease Hospital Admits	67%
50% Decrease in Psychiatric Emergency Services (PES)	65%
Primary Care linkage within 12 months of program enrollment	100%
Partners with Stable Housing	67%

FY 2017/18 Impact

The STAGES team has a deep impact on Partners' lives which creates relationships of trust with clients, family members and other community partners. These positive relationships enhance the ability to connect with Partners and help them recognize their own strengths and their challenges. This results in a collaboration with our partners about their goals and identification of small, achievable steps to help them work towards those goals. STAGES services are creative and highly individualized. Partners are able to improve their symptom management and decrease internalized stigma, experience improved relationships with loved ones and decrease re-hospitalizations for medical and psychiatric reasons.

Partners' Stories

A partner who is 78-year-old woman who joined STAGES in 2013. She spent her childhood moving around foster care and her adult years in board and care homes and psychiatric treatment. She presents as sarcastic and off-putting to others, which has led to a lifetime of social isolation. This year, with STAGES support, she has learned to utilize her artistic skills as a way to help manage her emotions, and has started attending the San Leandro Senior Center weekly, where she has new friends and takes dance and computer classes.

Another Partner who is a 70-year-old man, spent 18 months at Morton Bakar Center for treatment of his complex medical and psychiatric conditions. He is diagnosed with bipolar disorder which complicates his ability to manage his diabetes and renal failure and compromises his ability to attend life sustaining dialysis thrice weekly. STAGES supported this Partner with intensive services to help him discharge to his own apartment in Berkeley four months ago. We continue to visit him 4-7 times per week to support his management of his psychiatric symptoms and complicated health issues. He is enjoying the social scene at his building and attending water aerobics classes at the nearby public pool.

FY 2017/18 Challenges

Housing: Appropriately matched, decent housing in welcoming neighborhoods makes a tremendous difference in our partners' ability to remain successful in the community. Ongoing challenges for the STAGES team include a desperate need for affordable, appropriate housing options for our partners, at a continuum of levels of support. There is a need for affordable senior housing apartments that can be accessed quickly and can accommodate people with poor credit and erratic housing histories. There is a need for more licensed board and care homes that are competent at assisting our clients with their co-occurring mental health and medical needs.

Medical: There is a constant need for educating and advocating with medical providers to ensure that they are offered the same quality of medical care available to all community members. There is a need for skilled nursing facilities that will accept our partners with their complex mental health and physical needs.

A. COMMUNITY SERVICES and SUPPORTS (CSS) PROGRAM SUMMARIES

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD)

OESD 4a. Mobile Integrated Assessment Team for Seniors
Provider Name**:** City of Fremont

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

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

FY 2017-18 Outcomes

Number of unique consumers/ clients served: 65

FY 2017/18 Impact

Full implementation of Recovery and Resiliency (R & R) began in FY 2017/18. The program goals are:
1) Serve Senior Mobile Mental Health (MMH) clients that are stable
2) Provide mental health and supportive services to support stable community living
3) Sustain and support individual treatment goals and life goals.
It is the hope of the program that once clients successfully met their life goals, they will be discharge from the program. Three clients have now been discharged from the program.

The successful senior peer coach program continued to serve clients with lived experience with mental health challenges by matching peer coaches with peers who are socially isolated.
Another success is that the City of Fremont joined the international Age Friendly City Network. As an Age Friendly City, it is the hope that we will see major changes in community perspective on mental health; less stigma, increased knowledge and understanding of seniors afflicted by mental health problems.

Client's Story. Client is a 70 year old divorced Caucasian female. She was referred to MMH program by GART (Geriatric Assessment and Response Team). Client's brother from Arizona contacted ACBHCS and eventually GART for outpatient mental health services for the client. Client lives with her 80 year old aunt who owns the house they live in. Client has long history of mental illness (Bi-Polar Disorder) dating back in her early 20's and admitted that despite taking psychiatric medication prescribed by her psychiatrist, she still goes through difficult mood swings and has trouble sleeping. When in manic phase, she tends to do a lot of "gushing" or pouring too much of her emotions to other people which can cause some problems in maintaining healthy interpersonal relationship. In her depressed mood, she isolates herself, decreased motivation and has no energy to do anything. She often feels paranoid

around people and has a poor appetite. Client also suffers from multiple medical conditions including cardiac conditions and renal problems that require dialysis 3x/week.

Client now has increased coping skills, more insight into her symptoms, stable mood, more realistic expectations, more goal directed behavior and medication regimen effective in managing her symptoms. Client is now volunteering her time 1x/week at the main library, attends church and participates in church activities, sees and talks to her senior peer on a regular basis and getting herself ready to attend and participate in a weekly group therapy session. We are also working with client's family to support their understanding of Bi-Polar illness/symptoms, factors that influence it and role of medication and therapy. Family members are encouraged to participate in periodic maintenance session.

FY 2017/18 Challenges

Working with older adults, the program needs to acknowledge the multiple losses in our client's lives, including losing their significant others and other love ones, losing their health (medical, physical, vision, hearing, etc.), and losing some level of their independence (driving, cooking) or problems with mobility including falls. These factors have significant impact on clients reaching needed stability and functioning as there is constant changes that come with the loss as they experience increasing inter-dependence on care and support from their own families and other specialty care providers.

FY 2018/19 Projections

We recently hired a physician's assistant who will join our team in August 2018. We are happy to be able to fully support the complex medical and medication needs of our clients.

A. COMMUNITY SERVICES and SUPPORTS (CSS) PROGRAM SUMMARIES

OESD 5A/B. Crisis Response Program (South County)

Program Description:

Crisis Response Program (CRP) is an out-patient clinic that provides brief mental health services including case management, targeted crisis therapy, and psychiatry. On average, participants remain in program for 30-90 days. Once stabilized, participants are transferred to a level of care most appropriate to meet the participant's needs. Consumers who may not need specialty mental health services but need to be connected to a lower level of care such as primary care, substance use treatment, and other community services are also evaluated.

Target population:

Adults (ages 18+) who are living with a serious and persistent mental illness and are new to mental health services, uninsured, in crisis, and or being discharged from an acute psychiatric setting.

FY 17/18 Outcomes

Number of consumers served: 103

FY17/18 Impact

Participants are stabilized and assessed for the appropriate level of care for ongoing mental health services. The services are essential to developing rapport with BHCS's greater system, providing psychological education, introduction to psychiatry for some with medication adjustments for all, and brokerage with other social supports. For many, contact at CRP is their first introduction to out-patient services in Alameda County.

FY17/18 Challenges

Due to low numbers and facility issues, the Livermore site was closed approximately 2 years ago. Also the Tri-City (Fremont) clinician was on leave for nearly a year and coverage was provided by other clinicians in our program. Individuals were offered services at the Tri-City Clinic as needed but there was no need, as the clients were able to travel to Hayward for care. Individuals referred from Pleasanton/Livermore (Valley) area were able to get to the Hayward clinic for care. More effort is being made to quickly assess and assign to care those individuals who meet the need for specialty mental health services. Historically, bridge treatment was provided and longer time was spent on assessing individuals before transferring them to longer term services in BHCS. A number of individuals, (specifically those with severe functional impairments, chronic mental health challenges, and psychosocial stressors like homelessness), are negatively impacted by these brief treatment models which can often include many transitions within the Adult System of Care at BHCS. Participants continue to have the choice to receive care at our four sites: Oakland, Hayward, Fremont, Pleasanton/Fremont and Pleasanton sites are funded by MHSA.

Participants who are difficult to engage require more services in the community and CRP is reaching the goal of increasing the mobile crisis teams coverage to include the entire county. CRP is seeking to increase the prevention and early intervention activities through increased outreach and engagement services as well as adding post-crisis follow up for individuals to round out our crisis continuum of care. Participants are stabilized and assessed for the appropriate level of care for ongoing mental health services. The services are essential to developing rapport with BHCS's greater system, providing psychological education, introduction to psychiatry for some with medication adjustments for all, and brokerage with other social supports. For many consumers, contact at CRP is their first introduction to out-patient services in Alameda County.

A. COMMUNITY SERVICES and SUPPORTS (CSS) PROGRAM SUMMARIES

OESD 7. Mental Health Court Specialist (Court Advocacy Program)
Program Name: Court Advocacy Program (CAP)

Program Description:
CAP increases 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. CAP provides the following services:

1. Identify and Connect defendants with mental illnesses to treatment services while in jail and refer to community treatment for post release follow up.
2. Involve community treatment providers in the court process for their clients and notify them of court status to ensure continuity of care
3. Assist Judges, Public Defenders, DA's & Probation in understanding mental illnesses and treatment resources
4. Identify underlying issues leading to recidivism; i.e. Housing, Benefits, Medical Issues, Substance Abuse, etc.
5. Advocate for specialty mental health treatment, such as hospitalization for acutely ill, suicidal, and gravely disabled individuals
6. Assist family members in navigating the courts and the mental health system of care

Target population:
Justice involved adults age 18 and older with serious mental illness and co-occurring substance abuse disorder. Individuals must be eligible for diversion or re-entry services to the community. Consumers include Transitional Age Youth, Adults and Older Adults.

FY 2017/18 Outcomes

Number of unique consumers / clients served: 250

FY 2017/18 Impact

A large number of individuals who come in contact with the criminal justice system are not currently connected with mental health services. Families are often frustrated and have either cut off ties, or not sure where to turn for help for their family members. The Courts are also frustrated as they may feel the person is not appropriately placed in jail but also are concerned about the risk of releasing individuals to the community with no support and treatment system in place. In addition, many clients are homeless. The community is frustrated as they are often concerned as a collective why the mentally ill are ending up in jail, not connected with services. The law enforcement community has also expressed frustration about what to do when they are confronted with someone who is mentally ill and has broken the law, but could be diverted. A lot of attention is currently going towards diversion and re-entry programs for the forensically involved individuals with mental illness.

A. COMMUNITY SERVICES and SUPPORTS (CSS) PROGRAM SUMMARIES

The court programs staff provide education for the criminal justice community including the courts and the attorneys. They also provide education and help families navigate the court system. Staff develop diversion plans for clients and help connect them to treatment in the community. Sometimes clients are initially in custody other times they may be out of custody and involved with the court. With the changes of the legal system more and more clients are released from custody who still have charges and are not connected to treatment.

For those involved in Behavioral Health Court, they may have their charges dismissed, or may be connected with a FSP program that provides wraparound treatment. This includes assistance with finding housing, getting connected with benefits in the community if eligible, being assessed for an appropriate level of care by court staff, referrals and warm hand offs to programs and arranging for transportation to programs in the community.

Mental Health Court staff also ensure that clients receive discharge medication when they are transitioning to the community. This is vital as it can be the difference between someone successfully following thru with the discharge plan they have developed with the court staff person. With the addition of a mental health peer specialist, clients have been able to meet with a peer who can provide support with empathy and understanding. Being able to see someone who is in recovery serves as an inspiration to clients.

Consumer's Story

One example of the work the court diversion staff was involved in was when a young male was arrested after attempting suicide on the train tracks. By the time he had reached the jail, he became catatonic, unresponsive to external stimuli and needing support around being fed. He had been psychiatrically hospitalized numerous times while in custody, but despite this and constant monitoring by staff, the client lost a significant and dangerous amount of weight.

The young man had previously been psychiatrically treated through an out of county juvenile probation department. Unfortunately, the young man aged out and appropriate transition services in to Alameda County were never established. The young man was unexpectedly dropped off at his mother's home after having been in a group living situation with no medications or follow-up. Although he was fairly lucid at the time, his decompensation came rapidly after a few months, resulting in an assault on a family member and attempted suicide.

Because the young man was catatonic, he was unable to participate in his legal process. Initially, the court was going to discharge him to his mother's care and the charges were to be dropped with no treatment plan in place as had happened to him previously. However, the client's mother expressed great concerns that no services were in place, and that the client was returning to her in a worse mental state than she had ever seen. With the support, planning, and advocacy of the Court Mental Health staff and discharge planner, the client was transferred to a community facility, eventually stabilize and returned to his family home. The Court Mental health staff was able to connect the client to a Full Service Partnership (FSP) program which provided intensive case management for transitional age

youth. The efforts of the Court Mental Health staff treatment team resulted in this young man being able to safely return home, for his family to feel safe about their son returning home, and for the entire family to participate in this client's treatment and recovery.

FY 2017/18 Challenges

The primary challenge continues to be staffing as we have not been fully staffed during the 2017/18. We had a key staff member out of leave for most of 2018 which creates stress on the rest of the team. We were also short one clinician during 2017/18. We have been able to successfully add a Behavioral Health Clinical Supervisor to the team in April. Of course the forensic and court world requires a very special skill set so she continues her learning curve. The plus is she brings experience with community mental health services and resources. There still is not an accurate data tracking system and it is felt that many services go unaccounted for. Without accurate data, it is challenging to identify both successes and areas to improve.

FY 2018/19 Changes

The goal is for the team to be fully staffed. With the addition of new forensically focused FSP's and the increase in slots available in the community, it is hoped that the program will have more resources available for the population that they service. Effective July 1, 2018, Casa De La Vida, a 6 month transitional program, became a resource for the forensic population who are homeless. All individuals referred to the program will be connected to a community treatment provider and assisted in all areas of the transition to the community. With the addition of a supervisor to the team it is anticipated that there will be further development of the infrastructure.

A. COMMUNITY SERVICES and SUPPORTS (CSS) PROGRAM SUMMARIES

OESD 8. Juvenile Justice Transformation of the Guidance Clinic
Provider: Alameda County Behavioral Health Care Services

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

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

FY 2017-18 Outcomes

Number of unique consumers/ clients served: 768

FY 2017/18 Impact

The Guidance Clinic Behavioral Health Clinician (BHC) in the Transition Center supports justice involved youth and families in accessing supportive mental health services. The BHC maintains relationships with community based organizations (CBOs) to ensure continuity of care and support community connection. The BHC also serves as a liaison between agencies, supporting families as they navigate multiple complex systems.

Client's Story
One youth AJ (name changed) was referred to the Transition Center by a separate Guidance Clinic clinician due to history of panic attacks and ongoing anxiety. The Transition Center BHC met with AJ upon release and assessed anxiety symptoms, providing intervention tools and practicing breathing and grounding strategies. The BHC also met with AJ's mother; BHC discussed mother's perception of AJ's needs, mother's experiences with anxiety, psychoeducation about anxiety, and coping strategies. The BHC assisted the family by making a referral to a nearby CBO and directly connecting AJ and his mom with a newly assigned clinician to support the family's needs. The BHC maintained connections with AJ and his mother through follow-up phone calls and in-person interactions after court dates. AJ's mother reported that her son continued to engage in therapy weekly and improved his ability to manage his anxious responses.

FY 2017/18 Challenges

Several significant changes occurred in the 2017-2018 fiscal year that impacted service delivery and the number of clients served. For example, the Transition Center is comprised of several partner agencies (Guidance Clinic, Health Care Services Administration, Oakland Unified School District, Public Health, and Probation). Several of these agencies experienced changes in leadership this fiscal year which resulted in establishing new communication and system processes. These changes impacted workflow as the Behavioral Health Clinician and collaborative partners worked to re-establish systems and troubleshoot gaps in services. The Transition Center also underwent a major remodel during this time. The remodel resulted in a temporary displacement of staff and reduced face-to-face contact with families. Finally, the census of juvenile hall continues to decline, which is a positive trend that also lowers the number of youth and families served. For example, there were 67 youth in custody at the juvenile hall at the end of June 2017; at the end of June 2018, only 58 youth were in juvenile hall detention. Despite this decline,

juvenile hall continues to house many high mental health acuity youth that require referral and coordination to community mental health services.

A. COMMUNITY SERVICES and SUPPORTS (CSS) PROGRAM SUMMARIES

OESD 9. Multi-Systemic Therapy (MST)
Provider: Seneca Family of Agencies

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

Target population:
Youth referred are on probation in Alameda County and are at risk of out of home placement due to referral behavior and living at home with a parent or caretaker.

FY 2017-18 Outcomes

Number of unique consumers/ clients served: 46

FY 2017/18 Impact

Consumer's Story
MST is working with a young man and his father to focus on increasing positive communication and decreasing conflict in the home, increasing the youth's involvement in prosocial activities, his use of positive coping skills, and his overall level of hopefulness for his future. At the time of the referral from Probation, this young man had recently moved in to live with his father, who he had inconsistent contact with growing up. The youth's MST clinician has been meeting multiple times a week with the youth and his father and has supported his father in increasing his warmth in his communication and interactions with his son, for the purposes of strengthening their affective relationship. The MST clinician has provided psycho-education to the youth's father and probation officer surrounding the youth's extensive trauma history and triggers in order to identify alternative ways of communicating and interacting with the young man that won't trigger him to react with aggression or defiance. At the time of referral, this youth felt hopeless about his ability to get off probation and saw a future for himself that would end with life in jail, or dead. Through supporting the youth in accessing pro-social activities and completing his community service requirements, this young man has regained hope about getting off of probation and being able to finish school. Though treatment will continue, he is on track to be dismissed from Probation and he is excited about what the future holds. His father is actively working on providing praise to him, conveying warmth and love, and spending time with him. He reports that their relationship is not as conflictual as when the youth first moved in with him.

FY 2017/18 Challenges

The major challenge the program faced has been the decrease in the number of youth being served by the Juvenile Probation Department. During 2017, the program received considerably less referrals than previous years, which had a direct impact on the number of youth being referred to the Multisystemic Therapy program.

FY 2018/19 Projections

Due to the substantial drop in the in the number of referrals received, MST have had to reduce the number of staff from 2 teams, comprised of 7 clinicians to 1 team comprised of 4 clinicians, in the last year. We will remain at 1 team for the foreseeable future until we identify additional referral sources and/or the number of referred youth increases on a consistent basis.

A. COMMUNITY SERVICES and SUPPORTS (CSS) PROGRAM SUMMARIES

OESD 11. Crisis Stabilization Unit: Willow Rock Crisis Stabilization Unit (CSU)
Provider: Seneca Family of Agencies

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

Target population:
The Willow Rock CSU serves medically stable youth ages 12 to 17 years experiencing a mental health crisis. The program may serve up to a maximum of ten clients at a time. Youth may arrive on a WIC 5585 civil commitment hold or as a voluntary "walk-up" from the community. 57% of youth served during FY17-18 were enrolled in Medi-Cal as their primary insurance.

FY 2017-18 Outcomes

- Number of unique consumers/ clients served: 1008 unique clients
- 1228 admissions

FY 2017/18 Impact

41% of youth admitted to the Willow Rock CSU were diverted from inpatient treatment. When surveyed whether they felt welcome on campus, youth rated the CSU at an average of 3.64 out of 4, leaving comments such as "Thanks for the kindness" and "They made me feel at home." One caregiver stated, "Everyone was very kind and calming which I believe really helps the children and the family." Another said, "People were kind, patient, and informed. We never felt rushed."

One program development that bears highlighting is our collaboration with our partners at the Willow Rock Psychiatric Health Facility, and representatives from Alameda County and Patients Rights, to support youth in receiving voluntary inpatient treatment when indicated. This process has empowered families to enroll their child in the treatment they need voluntarily when appropriate and offered them greater agency in advocating for their child's mental health needs.

FY 2017/18 Challenges

One of the ongoing challenges for the CSU is providing effective crisis stabilization services to youth who are experiencing placement and attachment disruptions. Due to the many environmental stressors and trauma experienced by these youth, they may be more likely to return shortly after discharge from the CSU or inpatient treatment than youth discharged into family homes.

A. COMMUNITY SERVICES and SUPPORTS (CSS) PROGRAM SUMMARIES

OESD 13. Co-Occurring Disorders - Chrysalis
Provider: Horizon Services Inc.

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

Target population:
Chrysalis offers a 16-bed, community based residential treatment program serving participants who identify as female, 18 years and older who are affected by substance use and mental health related problems.

FY 2017/18 Outcomes

Number of unique consumers/ clients served: 61

FY 2017/18 Impact

Clients receive mental health and substance use services to address co-occurring issues that have been negatively affecting their lives. Most clients are not in one place for long and change housing situations often trying to survive on the streets. They don't have the means, knowledge or resources to contact a mental health provider and continue with consistent care. They self-medicate by using drugs. When they come into treatment, they are stationary long enough to let us connect them with psychiatric services, get on a medication regiment and receive the treatment they need.

Clients also feel cared for because there is staff on site 24 hours a day. We have a treatment team. So, they have individual sessions with a non-judgmental person that listens to them and meets them where they are at. There is a case manager that check in with the client and work to help the client get their needs met. For a lot of our clients this is a new experience. As well as staff, there are other residents that serve as support for each other with the shared goal of recovery.

Family members find relief that their loved one is in a safe place. They are usually grateful for the changes they see in their loved one. They are happy to have their family member back. They can begin to welcome the client back into the family and trust and depend on them. This takes the load off family members. Sometimes, the change in the client can cause stress in families. When one-person changes, it causes a ripple effect and others must change the way they relate to the client which sometimes causes the family to push against treatment.

Some families see the client in treatment as a chance to control the clients' lives. They see being in treatment as validation of what they've been trying to get the client to understand for years, they need help. These families try to control treatment.

Chrysalis has a reputation in the community as a high-quality treatment program. The courts have a place they can feel confident that they can send their defendants who need treatment. The courts know their clients will get quality service.

A. COMMUNITY SERVICES and SUPPORTS (CSS) PROGRAM SUMMARIES

Consumer's Story

There was a client in her 50s who was homeless and had been drinking for many years. Her children were the ones she was most concerned about in terms of how her drinking affected them. Once in treatment, one of her children was so relieved and happy, he would send her packages of items she needed. He would write her letters including her in the happenings of his life. During her drinking, she overstepped one of her children's boundaries. He never contacted her while she was in treatment. However, his brother would keep his mother updated on what was going on with him. She also had an "adopted" family. They had known her for many years and were so relieved and happy that she was in treatment, they would give her rides to appointments or money to help her out now that she wasn't drinking anymore. They would give treats to the program for all the residents as a way of giving back to the program that was helping their loved one.

FY 2017/18 Challenges

- Lack of staffing to support the clientle in order to provide quality services
- Lack of collaborative resources i.e. housing; psychiatric care, psychiatric evaluation, medication, etc.
- Lack of funding creating barriers to recruiting appropriately qualified trained staff
- Limited training for staff in co-occurring disorder treatment
- Difficulty reconciling different treatment approaches to address co-occurring disorders
- Two separate systems providing mental health and substance use treatment services is problematic in the treatment of co-occurring disorders
- Primary mental health issues and secondary substance use makes documentation challenging because it does not show a complete picture of the co-occurring disorder.

FY 2018/19 Projections

We are working with consultants and starting discussions with staff and clients to provide more culturally responsive services and environments to our clients of color and transgender clients. Clients of color make up over 60% of our intakes. We are also in the process beginning trainings for our Client Support Specialists (CSS) to improve their skills in working with the co-occurring population. Our CSS staff has strong backgrounds in Substance Use Disorder. However, we would like to make sure clients get quality treatment that addresses all their needs from all staff. Lastly, we are moving towards a more trauma informed care model of treatment. We are looking at ways to increase retention and decided we needed to start with safety. This means that we need to be able to provide care that takes the clients' trauma in consideration, helping the client feel safe and hopefully keeping them in treatment.

A. COMMUNITY SERVICES and SUPPORTS (CSS) PROGRAM SUMMARIES

OESD 13. Co-Occurring Disorders - Cronin House
Provider: Horizon Services, Inc.

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

Target population:
All-gender inclusive and serves adults with co-occurring diagnosis.

FY 2017-18 Outcomes

Number of unique consumers/ clients served: 180

FY 2017/18 Impact

Consumer Story

One of our clients, alias Sam, was part of our program for approximately 1.5 months. In this time, she demonstrated very impulsive behaviors and struggled to understand what was being communicated during group therapy sessions. Her behavior would frequently include loud verbal interruptions of peers and negative peer interactions/arguments. This client would not take responsibility for any program rule violations, even when a staff person witnessed the situation and attempted to intervene. In discussions about transition after treatment, the client refused to entertain any options being presented by her clinical counselor, even when her desired outcome (living with her parents) was no longer an option due to her parents' refusal to allow her into their home. Sam became paranoid about her medications and concerned with side-effects, so she refused to take her medications, and thus started to struggle more with "hearing voices" and inability to focus. Ultimately this client was not able to complete treatment, and continued to have a conflict-filled relationship with her parents and family.

Sam required an extreme amount of individualized attention/support, as she needed constant reminders about positive interactions with staff to build her trust with the program. She required smaller group sizes to reduce the voices that constantly overwhelmed her, and she struggled to share her bedroom with peers while in the program. In a program that is group-based, it was very difficult to determine how much therapeutic benefit she was gaining, as her behavior demonstrated a constant state of fear, paranoia, and distraction. This is a common scenario we face in a short-term residential program, as we have extremely limited amounts of time to gain a client's trust, build rapport, determine appropriate diagnosis, and make progress on therapeutic work, while still caring for a large number of other clients and addressing family needs simultaneously.

FY 2017/18 Challenges

This program is all-gender inclusive and serves adults with co-occurring diagnosis. In a program that only lasts up to 90 days, this presents a variety of challenges, including sexualized behavior/interactions distracting clients from treatment. Furthermore, many of our clients arrive at our facility with misdiagnosis and inappropriate medications being prescribed. With such a short amount of time to work with the clients, we spend nearly half of the client's time in treatment working towards building trust/therapeutic rapport and determining the appropriate diagnosis and medications for the client. That limits the ability to provide case management and more in-depth therapeutic work to address family dynamics, substance use patterns, and transition planning. In some cases, the clients are prescribed addictive medications to address mental health diagnoses, which directly impact the substance use treatment for the client. There are also very few facilities capable of working with both mental health and substance use, as many treatment centers specialize in one or the other.

It is widely acknowledged that for clinical groups to be beneficial for clients, the ideal ratio of clinical counselor to clients is between 1:10 and 1:12. The clinical team generally has more experience, education, and skill, than other direct-care staff members; however, the ratio for non-clinical staff members to clients during evening and weekend hours can be as challenging as 1:34. It is only through high levels of creativity and staff flexibility that we can get the ratio closer to 1:16, which is still not therapeutically ideal.

A. COMMUNITY SERVICES and SUPPORTS (CSS) PROGRAM SUMMARIES

OESD 13. Co-Occurring Disorders Program - - Alcohol, Tobacco & Other Drugs (ATOD)
Provider: Thunder Road

Program Description:
ATOD Provider Network Tobacco Dependence Treatment Training is a training and technical assistance project to improve clinical skills on how to provide evidence-based tobacco dependence treatment. This program's staff provides consultation to BHCS staff regarding tobacco-free policies and helped to develop the 2016 BHCS Tobacco Policies and Consumer Treatment Protocols. Program outreach and training is county wide, and targets/encompasses staff who work anywhere to provide any BHCS services to any age group. Services are provided to BHCS programs and agencies contracted with BHCS and include Alameda County consumer run agencies. Only half of the ATOD Network is paid for by BHCS funds. The other half is funded by the Alameda County Public Health Tobacco Control Program.

Target population:
ATOD's targeted population is BHCS-funded mental health and substance use disorder (SUD) direct service programs; and BHCS County-run mental health programs of any age group.

FY 2017/18 Outcomes

- Number of unique consumers/ clients served: 270
- 9 trainings and 2 Tobacco Learning Conferences

FY 2017/18 Impact

The project trained 270 clinicians from a broad spectrum of mental health and SUD programs to perform culturally appropriate tobacco interventions and implement tobacco policies through 9 on-site trainings. Collaborative work continued with Peers consumer agency regarding the use of nicotine replacement therapies with clients in groups. Supporting Peers in their implantation of a tobacco support group has motivated Peers to incorporate a group for those exploring to quit tobacco use into their ongoing program without additional funding. ATOD provided intensive technical assistance to 6 BHCS tobacco intervention in recovery mini-grantees designed to improve recipient agencies' competency in interviewing with their clients who smoke. A uniform Tobacco Use Assessment was developed and has been adopted by a number of agencies.

Both learning conferences were able to provide the basics of tobacco treatment, and how to integrate the BHCS Tobacco Policy into providers' treatment service programs. The conferences also provided a larger forum to address new and emerging issues arising from the tobacco industry's tactics. Along with information on tobacco industry's latest technology for receiving tobacco, the second conference, in spring 2018, also provided training focused on how menthol tobacco usage has targeted specifically the African American community and vulnerable populations.

FY 2017/18 Challenges
Although the delivery of the message to implement tobacco policies has been delivered to agencies, there remains a belief with some staffers they do not have to implement the policy. There is also a barrier of time and interest with some providers to have staff attend trainings or provide an on-site training. It is believed the stoppage of funding for tobacco mini-grants is a major barrier. These mini-grants were used to assist providers to purchase incentives for support groups and pay for starter evidence-based over the counter nicotine replacement therapies.

FY 2018/19 Projections

Although half the monies are contributed by Alameda County Public Health Tobacco Control Program, the program has generally been contracted and managed by BHCS. During FY 2018/19, project management will be shared between the two divisions. Public Health has now added a number of new deliverables including, but not limited to, providing support to non-behavioral health providers, and supporting Alameda County residents in decreasing tobacco use.

Due to the end of the mini-grant programs, other avenues are being explored to fund nicotine replacement therapies. A broader protocol for residential SUD programs to administer medication which includes a section on nicotine replacement therapies was drafted in conjunction with BHCS' medical director's office. The protocol is currently being reviewed by the state as part of the Medi-Cal waiver process. It should be noted the protocol does not address ambulatory agency needs to provide starter medication to optimize implementation of tobacco treatment.

A. COMMUNITY SERVICES and SUPPORTS (CSS) PROGRAM SUMMARIES

OESD 17. Residential Treatment for Co-occurring Disorders
Provider Name: Horizon Services, Inc. **-** Cronin House

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

Target population:
This program is all-gender inclusive and serves adults with co-occurring diagnosis. In a program that only lasts up to 90 days, this presents a variety of challenges, including sexualized behavior/interactions distracting clients from treatment. Furthermore, many of our clients arrive at our facility with misdiagnosis and inappropriate medications being prescribed. With such a short amount of time to work with the clients, we spend nearly half of the client's time in treatment working towards building trust/therapeutic rapport and determining the appropriate diagnosis and medications for the client. That limits the ability to provide case management and more in-depth therapeutic work to address family dynamics, substance use patterns, and transition planning. In some cases, the clients are prescribed addictive medications to address mental health diagnoses, which directly impact the substance use treatment for the client. There are also very few facilities capable of working with both mental health and substance use, as many treatment centers specialize in one or the other.

FY 2017-18 Outcomes

Number of unique consumers/ clients served: 180

FY 2017/18 Impact

Consumer's Story

One of our clients, alias Sam, was part of our program for approximately 1.5 months. In this time, she demonstrated very impulsive behaviors and struggled to understand what was being communicated during group therapy sessions. Her behavior would frequently include loud verbal interruptions of peers and negative peer interactions/arguments. This client would not take responsibility for any program rule violations, even when a staff person witnessed the situation and attempted to intervene. In discussions about transition after treatment, the client refused to entertain any options being presented by her clinical counselor, even when her desired outcome (living with her parents) was no longer an option due to her parents' refusal to allow her into their home. Sam became paranoid about her medications and concerned with side-effects, so she refused to take her medications, and thus started to struggle more

with “hearing voices” and inability to focus. Ultimately, this client was not able to complete treatment, and continued to have a conflict-filled relationship with her parents and family.

Sam required an extreme amount of individualized attention/support, as she needed constant reminders about positive interactions with staff to build her trust with the program. She required smaller group sizes to reduce the voices that constantly overwhelmed her, and she struggled to share her bedroom with peers while in the program. In a program that is group-based, it was very difficult to determine how much therapeutic benefit she was gaining, as her behavior demonstrated a constant state of fear, paranoia, and distraction. This is a common scenario we face in a short-term residential program, as we have extremely limited amounts of time to gain a client’s trust, build rapport, determine appropriate diagnosis, and make progress on therapeutic work, while still caring for a large number of other clients and addressing family needs simultaneously.

FY 2017/18 Challenges

It is widely acknowledged that for clinical groups to be beneficial for clients, the ideal ratio of clinical counselor to clients is between 1:10 and 1:12. The clinical team generally has more experience, education, and skill, than other direct-care staff members; however, the ratio for non-clinical staff members to clients during evening and weekend hours can be as challenging as 1:34. It is only through high levels of creativity and staff flexibility that we can get the ratio closer to 1:16, which is still not therapeutically ideal.

A. COMMUNITY SERVICES and SUPPORTS (CSS) PROGRAM SUMMARIES

OESD 19. Medication Support Services
Provider: Hiawatha Harris, M.D., Inc./Pathways to Wellness Medication Clinic

Program Description:
Pathways to Wellness provides the following clinic-based services based on the acuity client of needs to promote successful transition of patients to primary care.

- Medication Support Services including Initial Assessment and Follow-up Assessment
- Issuing medication prescription(s) for the right drug therapy for client
- Administration of injectable medication, when applicable
- Evaluation and monitoring including consultations with physicians, clients and family members as authorized by the client. Face-to-face evaluation and monitoring for possible drug interactions, contraindications, adverse effects, therapeutic alternatives, allergies, over/under dosing, polypharmacy, side effects, adverse effects, dietary conflicts or any other medication related issues
- Mental Health Services including Assessment, Collateral, Plan Development, Individual Rehabilitation, Brief Individual and/or Group Therapy. Case Management/Brokerage and Crisis Intervention Services.
- Outreach efforts made in the field by a psychiatric nurse specifically in North County to meet that client demand

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

FY 2017-18 Outcomes

Number of unique consumers/ clients served: 2,888

Pathways achieves ongoing success through the microcosm of each client we serve. Our clients have ongoing serious mental health disorders and find solace and comfort when they have complex symptoms especially without treatment. Pathways provides ongoing support to individuals by treating their symptoms with behavioral health interventions, providing resources, and providing quality medical treatment and medication management. When we provide healing and recovery to the individual consumer, the entire family system and community at large is impacted by the changes the client encounters. The well-being of a client's health can create stress or offer hope to client's macro system. In addition, we meet with family members to provide compassionate support to the entire family system. We have strong partnerships with community members and agencies. We have ongoing collaborations with primary care providers and various community partners.

Consumer's Story
A few months ago, a new client to Pathways was referred by John George Psychiatric Pavilion and was given an appointment within a few days after their release. The client who suffered from Schizophrenia

was hospitalized due to harm to self. Upon arrival, they struggled with feelings of safety as they have a comorbidity of severe and pervasive symptoms caused by Post Traumatic Stress Disorder (PTSD). The client was agitated and overwhelmed in the waiting room. The care coordinators were able to check-in with the client one-on-one to reduce the stimulation that was contributing their agitation. When checking in with the nurse and the psychiatrist they engaged the client with information about their primary care provider (PCP) and coordinated care. The client signed a release and coordination of care with the family was created. The family came into the next session with the psychiatrist and a plan was put into place so that the client could have more encouragement with medication management and to attend to their health care issues with the PCP. Their case manager supported their resources and daily functioning. After ongoing engagement with all of the client's providers and family, the client was able to begin medication compliance for the first time and as a result, has remained out of the hospital and has not been arrested, which is something this client has struggled with for many years. The dedicated staff at Pathways who advocated on behalf of this client increased the welfare of this client and his family. With further care, the client's life skills will hopefully be increased and stress reduction may be decreased.

FY 2017/18 Challenges

Challenges have increased due the available number of Level Two and One programs in Alameda County. Additionally, we experienced a significant increase in the number of consumers in need of level three services.

Additional types of ongoing issues include:
a) High number of new clients who are given appointments but high percentage that do not show up for their first appointments. This leaves new clients at risk for decompensation or use of higher levels of care.
b) For consumers/ clients with moderate to severe mental health impairments with very limited support services, intensive case management is needed in order to secure housing, transportation and benefits.
c) A number of our clients are challenged by not having funds to get into clinic for appointments; no transportation equates more likelihood of missed appointments.
d) Clients are not transitioning out fast enough to the FQHC/PCPs to balance the demand of new clients in need of Pathway to Wellness services. Therefore Pathways is faced with keeping up with *ACCESS* new client referrals while consistently trying to locate lower level of care options for clients who are ready for discharge.

FY 2018/19 Projections

Pathways plans to increase engagement and care management services by focusing more engagement activities on the front end as well as after enrollment. For an example, we have instituted an outreach nurse who goes to John George Psychiatric Facility prior to discharge to initiate engagement efforts which, we believe, will increase our changes of client actually making it into first appointment at Pathways. We will also add on case managers in 2018-2019 to ensure that we have designated staff targeting clients who are more at risk of falling out of treatment. Pathways will also discontinue children's services after December 31, 2018 as those medication clinic services will shift back to the county and into county clinics to support Alameda County's new children's plan. We have been providing these services for 19 years. Approximately 600 children will be impacted by this shift in terms of no longer accessing Pathways service model.

A. COMMUNITY SERVICES and SUPPORTS (CSS) PROGRAM SUMMARIES

OESD 19. Medication Support Services
Provider: Telecare - STEPS

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

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

Individuals who are high users of Alameda County Mental Health Services are referred to STEPS from Subacute Mental Health Rehabilitation Centers (i.e., Villa Fairmont or Gladman IMD), or by Alameda County BHCS when applicable. The referral is reviewed by the Clinical Director for completion and eligibility. The individual is assigned a case manager on the team and the outreach begins usually while the individual is still living in the IMD and preparing for discharge to the community. STEPS provides case management services in the community, including psycho-educations (individual and family), symptom management, medication tracking and coordination with pharmacies/providers, coordination of health care services, increasing social supports, accessing/locating community resources, housing search/education, and independent living skills training.

FY 2017-18 Outcomes

Number of unique consumers/ clients served: 73

2,549 individual charted services with clients, and estimated 350 outreach contacts made with referrals in preparation for consumers returning to the community.

FY17/18 Impact

STEPS provides support to individuals around re-entry to the community from long-term hospitalizations. We assist clients with connecting to PCP/psychiatry services, coach and instruct clients around developing and practicing coping strategies from Evidenced Based Practices, explore and locate safer housing options, connect with community groups and activities including employment services, provide psycho-education around understanding diagnosis and symptom management, understanding and accessing resources and services, and increasing self-advocacy skills.

STEPS demonstrated a decrease in hospitalizations, decrease in incarceration/recidivism rates, increase in acquisition of state and federal benefits, improved housing stability by number of days housed, increase in medication maintenance, and 100% connection with PCP and psychiatry services.

A. COMMUNITY SERVICES and SUPPORTS (CSS) PROGRAM SUMMARIES

FY 2017/18 Challenges

The current challenge is predominantly around locating and securing safe and affordable housing, but we also find it challenging at times to coordinate with multiple specialty medical services due to time delays and the complexity of organizing multiple providers.

We work closely with county leadership to develop housing resources and increase coordination with service teams and specialty providers. We develop relationships with county service team and HSP programs to provide extra support for clients with complex needs.

A. COMMUNITY SERVICES and SUPPORTS (CSS) PROGRAM SUMMARIES

OESD 20. Individual Placement Services (IPS)
Provider: Alameda County Vocational Services

Program Description:
BHCS Vocational Services - IPS is a part of the Adult System of Care for Behavioral Health Care Services that is imbedded in 15 different county operated and community based service teams and specialty mental health programs, including Conditional Release, the TRUST Clinic, Asian Health Services, Casa Del Sol and La Familia. Alameda County Vocational Services also oversees 9 different CBOs that have incorporated IPS into their service delivery. Our service approach, is to partner with the consumers and engage them around their unique interests and needs in finding a job, meet them in their community to identify employers, apply for jobs and assist with retention, while continuing to collaborate with their clinical team and significant others to aid in their success. The IPS model is seen as a treatment intervention. After a consumer is working, we continue to work with them until the job is secure and the individual is satisfied with the job match. If they want a different job or lose the one secured, we keep working with them as long as they are interested and motivated to work. There is a "zero exclusion" approach to recruiting consumers for services, which means that as long as they are motivated to work and have expressed interest, they will be engaged despite any presenting barrier. This includes whether a person compliant on medications, homeless, demonstrating positive symptoms of their condition, using drugs and alcohol, etc.

Target Population:
Assists youth (16 -17 yrs old), Transitional Age Youth (TAY -18-24yrs. old) and Adults and Older Adults in finding and keeping competitive work using the Evidenced Based Practice of Individual Placement and Support – Supported Employment. IPS services span from the Tri-Valley, Tri-City and mid-county locations.

FY 2017-18 Outcomes

Number of unique consumers/ clients served: 258

- Vocational Services is reviewed annually based on the 25 standard Fidelity Review by external reviewers and has sustained a "good' level of fidelity. (115 - 125 = Exemplary Fidelity, 100 -114 = Good Fidelity, 74 - 99 = Fair Fidelity, 73 and below = Not IPS)
- 46% job placement rate
- Secured 177 jobs during the FY 17/18
- Expanded direct services programming to serve youth ages 16-17

FY 2017/18 Impact

Consumer's Story

When consumers begin Vocational Services, many are hesitant and unsure whether they are capable of working. Many have never worked a competitive job and others have done their best to work, but have not been able to secure and retain a job for very long, with their illness getting in the way. One consumer from a county Community Support Clinic had been interested in working for over 20 years. She had worked in a sheltered – non-competitive project for a while, but otherwise wasn't sure if she could work a "real job". Her provider team wasn't sure either. She struggled with her mental illness and

was also profoundly self-conscious about how she looked. She had a skin condition that covers her body and she would wear clothes that covered her face, didn't attend to regular hygiene practices and generally didn't look people in the eye when she spoke to them. Her clinician referred her to Vocational Services and she was assigned an employment specialist who really worked to show her what she is capable of doing. She was coached on how to present herself, they identified clothing that the client felt good about. She was supported on being proud of who she was. She went on 14 different interviews and, was hired at a grocery store! The client worked long enough to save money to visit her family in another state. She left that job, but was able to visit her family for three weeks and has continued presenting with pride in her hair style, clothing and hygiene. She is now back in Oakland and is picking up with her employment specialist to find another job. This time around she has more confidence and her treatment team sees a different side of her, too, and also have renewed hope for her future in health and wellness.

FY 2017/18 Challenges

The biggest challenge in this fiscal year has been to fill vacant staff and supervisory positions. Staff have retired and promoted to better jobs faster than the civil service human resource department can keep up. With a 2.8% unemployment rate for the Bay Area, county jobs are not necessarily the best available, when there are so many more options. There have been candidates that left after being on the job a week and turn down job offers earning $90K starting, which was not seen just a few years ago.

FY 2018/19 Projections

Vocational Services has expanded to two divisions – a direct service unit (which serve the 15 programs noted earlier) and a technical and training unit which also reviews other community based programs that are using the IPS model. This is not a change from the past fiscal year, except that there are several negotiations in process to expand the number of programs that are overseen using IPS. There are currently 9 CBO contracts that are reviewed annually and provided technical assistance. In addition, IPS will be incorporated with the CalWORKS Welfare to Work with four new mental health providers in the next year. There is an agreement to move forward to incorporate IPS in the Whole Person Care – AC3 project, have employment specialists at the four clinics and imbedded with the Housing Navigators at two sites. Additionally, a proposal was initiated to incorporate IPS into the Juvenile Justice Mental Health Program and was included in a bid for an African American Male Housing/Case Management program. There are also efforts to extend IPS to the Adult Probation department.

A. COMMUNITY SERVICES and SUPPORTS (CSS) PROGRAM SUMMARIES

OESD 23. Community Based Voluntary Crisis Services
Transition to Mobile Crisis Teams (MCT) & Mobile Evaluation Teams (MET)
Provider: Alameda County BHCS

Program Description:
The Mobile Crisis Teams will respond to 5150 calls, engage with consumers who are in crisis, and assessment consumer needs and conduct follow up post crisis situation. MCT & MET will transition BHCS CRP from providing outpatient clinic services to only Mobile Crisis Services, with all CRP clinical staff to work primarily out in the field. An expansion of these services will increase the community-based crisis prevention and early intervention services, thereby ensuring clients are referred to the appropriate type of mental health services.

FY 2017-18 Outcomes

Number of unique consumers/ clients served at MCT: 439

Number of unique consumers/ clients served at MET: 217

FY 2017/18 Impact

The transition of our mobile teams from just evaluating individuals for involuntary hospitalization to teams focused on thorough outreach, assessment, diversion, and better care coordination is now an essential part of our Crisis Continuum of Care. Recently,

Consumer's Story
Recently, a parent contacted a former BHCS employee asking for assistance with his 30 year old son. This individual had been treated in the Transitional Age Youth System of Care and discharged to primary care before aging out of the program. At the time of discharge, the young man was stable, housed, and participating other community activities that could lead to employment. However in the past year, this young man had stopped taking psychiatric meds, developed a substance use disorder, had recent contact with acute psychiatric care settings, and is now at risk of eviction. The father was not sure who to turn to for help. Within 12 hours of the referral, mobile crisis met with the property manager and the young man at his residence. He did not meet criteria for involuntary hospitalization that day, and the team spent some time discussing the services available to him in the Adult System of Care (case management, help to maintain housing, medication support, crisis stabilization, and SUD treatment). By the end of the meeting, the young man had agreed to case management services and was promptly assigned to a team near his home. He was also opened to IHOT and STEPS, thus creating a web of support to securely connect him to his case management team. Mobile crisis has the ability to provide this urgent care in the community and will continue to be a part of this type of care coordination. In this case, the care coordination involved mobile crisis, a case management team, the office of Family Empowerment, the ACCESS Line, IHOT, and STEPS.

FY 2017/18 Challenges

Mobile teams receive the majority of referrals from law enforcement. Alameda County is very diverse and each law enforcement agency has different needs for mental health support during crisis mental health calls. For example, the mental health support needs in Oakland are very different than the needs of Pleasanton or Fremont. Some cities have more homeless encampments, and others have residents with wider a range of socio-economic status. Even the number of schools in a city can impact the

frequency and complexity of crisis mobile team calls for service. In an effort to meet the needs of the community and the law enforcement agencies that utilize our resource, we have been looking at offering a range of field teams. Our teams will continue to respond to urgent mental health calls as well as provide outreach and engagement, crisis intervention, assessment, diversion, case management/care coordination, post-crisis follow up, and referral to a variety of dispositions. This expansion will of course require hiring more staff which is often a barrier for many local agencies due to the Bay Area's high cost of living.

FY 2018/19 Projections

BHCS are looking at including those with lived experience and now in recovery (peers) as part of our post crisis follow team, and are planning to provide the following services listed below:

Clinicians will be out in the field performing the following activities:

- Engaging with consumers, conducting follow-up calls
- Conduct outreach activities
- Engage in prevention visits to shelters, Board and Care Homes, homeless encampments, schools, substance recovery programs and County clinics
- Collaborate with physicians for consultation as needed.
- Interact with police jurisdictions and ACCESS.

Program Staff will comprise of 24 full-time clinical staff and 3 full-time clerical staff. There will be 2 North County Teams, 2 Mid-County Teams and 2 South County Teams.

Training: All clinical staff will go through the following training when transitioning from outpatient clinic services to the mobile crisis team structure:

1) Crisis Prevention Institute's "Non-Violent Crisis Intervention" Training
2) Oakland Police Department's Crisis Intervention Training (CIT)
3) Screening, Brief Intervention, Referral to Treatment (SBIRT)
4) Stages of Change
5) Conducting Crisis Intervention throughout the Lifespan
6) Providing Culturally Responsive Crisis Intervention
7) Documentation
8) Differential Diagnosis
9) Co-occurring Disorders
10) Performing Crisis Intervention through a Trauma-Informed Lens
11) Environmental Awareness - Safety in the Community
12) Video Interpretation and Video Physician Consultation on iPad Devices
13) Performing Differential Diagnosis

A. COMMUNITY SERVICES and SUPPORTS (CSS) PROGRAM SUMMARIES

OESD 24. Schreiber Center
Provider: Alameda County Behavioral Health Care Services

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

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

FY 2017-18 Outcomes

Number of unique consumers/ clients served: 55

FY 2017/18 Impact

Schreiber Center clinicians continue to increase assessment and differential diagnosis competencies for individuals with developmental & intellectual disabilities (DD/ID). This has resulted in better matched care to address mental health needs for RCEB clients referred as well as improved therapeutic and psychiatric treatment for these individuals. Additionally, clinicians and supervisor have provided consultation and education about serving the clients shared by both the ACBHCS & RCEB communities. Such consultation and outreach opportunities include: ACBHCS ACCESS, John George Psychiatric Pavilion and RCEB's Provider/Vendor Advisory Committee.

Consumer's Story

The consequence of Schreiber Center's strengthened community presence and increased accessibility is improved client care. For example, following a presentation to the social work team at John George Psychiatric Pavilion, a man with bipolar affective disorder and also cerebral palsy was identified as needing outpatient mental health supports. His parents reported that he needed more than primary care to manage his mental health needs. Rather than wait for his RCEB case manager to complete the referral process, his supported living provider (SLS) quickly completed the paperwork. The client was seen soon after discharge and provided therapy and meds management. This client returned to his day program and his mood dysregulation has improved and no need for re-hospitalization.

FY 2017/18 Challenges

Small staff size and finite resources continues to limit the number of clients who can be served clinically. We continue to collaborate with RCEB on funding options with the hope of increasing capacity. Schreiber Center hopes to host and supervise a student intern for Fall 2018. Inviting an intern to join the

team will increase capacity and contribute toward the development of a workforce that is competent to serve individuals with intellectual and developmental disabilities.

FY 2018/19 Projections

Schreiber Center anticipates significant change in FY 2018-19. While the center's primary clinician is on maternity leave, a full-time TAP was hired and is being trained to serve her current caseload. The TAP will facilitate referrals, open charts, provide therapy and continue to grow the program.

The Schreiber Center Advisory Committee was developed in February 2018 to review sustainability of the program and address the current flow of referrals. The group has worked together to increase accessibility by opening portals for referrals. Previously only RCEB case managers could refer clients to Schreiber Center, now all providers (aka: vendors) of RCEB services can refer. The advisory committee also encouraged and supported ACBHCS in applying to become a vendor of RCEB services. Should the application be approved, Schreiber Center will be permitted to serve individuals who do not meet specialty mental health criteria or who are otherwise not eligible for county services.

While serving a broader spectrum of individuals, the above mentioned changes are also expected to increase referrals and grow both the clinical and psychiatric caseloads. Considering this likelihood, Schreiber Center anticipates a need for increased clinical staff and has made these projections and desires known.

A. COMMUNITY SERVICES and SUPPORTS (CSS) PROGRAM SUMMARIES

OESD 25. Behavioral Health - Primary Care Integration Project
Program: Oakland-PATH/ LifeLong Medical Care

Provider: LifeLong Medical Care

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

Target population:
PATH services are offered to all adults assigned to the service team at the support center.

FY 2017-18 Outcomes

- Number of unique consumers/ clients served: 248 clients;
- 600 primary care visits

FY 2017/18 Impact

According to BHCS and LifeLong medical staff, the integration project has been extremely beneficial to clients, making it easy to schedule and keep doctors' appointments, allowing the client additional time with the provider for the development of a greater understanding of the client's needs, having support staff to assist with medication management and to serve as a liaison between the primary care provider and the client. The project has also been beneficial to providers, who now have greater confidence that there is follow up on their instructions for client care and referrals to specialized services, especially with the nurse on site.

Consumer Stories from LifeLong Medical Care/PATH Clinic

A great success has been increasing participation of clients in the Substance Abuse Treatment program on site (85 attended in Year 2). A Substance Abuse Treatment group facilitator noticed that a client, while in group, was presenting off of his baseline. A counselor conducted an individual interview with the client and discovered that his medications had run out three days prior and he had not slept for 48 hours. The counselor took the situation to the center manager, who was able to get him in to see Dr. Noe immediately. Dr. Noe was able to prescribe two weeks of medication to fill the gap until the client could see his psychiatrist. We have had several of these examples of how coordinated care can work.

FY 2017/18 Challenges

It is often a challenge to coordinate services for patients who come to the PATH primary care clinic from Behavioral Health entities other than the Fremont site. Team meetings with case managers at OCSC are used to help everyone to increase communication and collaboration.

Substance abuse is a challenge for a number of clients, and the center staff have been attempting to put in place a confidentiality agreement that would give permission for our Substance Abuse Treatment team (addiction counselors from Options Recovery Services) to attend weekly case conferences to

discuss client care. The Substance Abuse Treatment groups take place every Monday, Thursday, and Friday.

It has been a challenge to begin services at the Eden Adult Community Support Center, as that center is working to prepare a space where the primary care clinic can operate.

FY 2018/19 Projections

No major changes are planned in service delivery for the coming year.

A. COMMUNITY SERVICES and SUPPORTS (CSS) PROGRAM SUMMARIES

OESD 25. Behavioral Health - Primary Care Integration Project
Program Name: Fremont-PATH

Provider: Tri-City Health Care

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

Target population:
PATH services are offered to all adults assigned to the service team at the support center.

FY 2017-18 Outcomes

- Number of unique consumers/ clients served: 107 clients;
- 405 primary care visits

FY 2017/18 Impact

According to staff at BHCS and at Tri-City Health, the integration project has been extremely beneficial to clients, making it easy to schedule and keep doctors' appointments, allowing the client additional time with the provider for the development of a greater understanding of the client's needs, having support staff to assist with medication management and to serve as a liaison between the primary care provider and the client. The project has also been beneficial to providers, who now have greater confidence that there is follow up on their instructions for client care.

Consumer Stories from Tri-City Health Center/PATH Clinic

"Due to her diagnosis, "Sue" (name changed to protect identity) usually has a hard time trusting her primary care providers, and often her needs would not be met because she will make multiple calls and asks the same questions over and over again. Client reports that since she moved to the PATH Project, her primary care provider is patient with her and she is able to get answers. She recovered from her ear infection --something she was receiving treatment for several months without any relief, with her prior physician."

"The client's overall disposition and depressive symptoms have reduced with the news of imminently receiving his motorized wheelchair."

"Detection and hospitalization for low sodium for "Joe" (name changed to protect identity) led to further investigation, and it seems increasingly likely that the low sodium was a result of his psych meds. His medications have been adjusted: care coordination between PATH and his psychiatrist helped stabilize the client."

FY 2017/18 Challenges

Substance abuse is a challenge for a number of clients, and the center staff have been attempting to put in place a confidentiality agreement that would give permission for our Substance Abuse Treatment

team (Options Recovery Services addiction counselors) to attend weekly case conferences to discuss client care. The Substance Abuse Treatment groups take place every Tuesday.

Another challenge is to engage more clients in wellness activities.

FY 2018/19 Projections

For the coming year, Tri-City Health is planning on changing their full day clinic to Thursdays and starting a half-day clinic on Tuesday afternoons.

A. COMMUNITY SERVICES and SUPPORTS (CSS) PROGRAM SUMMARIES

OESD 26A/B/C Culturally Responsive Treatment programs for African Americans
Program Description:
A Steering Committee has formed and convened to discuss funding priorities and identified several keys values that shape recommendations for funding.

The Office of Ethnic Services, in collaboration with the Network Office, is working to procure a series of culturally congruent mental health services for the African American community. In FY 2018-2019, there are three Community Services & Support funded services in the pipeline. The contract start date for all three services is expected in the Fall of 2018. Those programs are:

1. **OESD 26A Training and Technical Assistance on Accurate Diagnosis and Appropriate Medication Treatment and Healing Practices for African Americans**

   The overarching goal of the Training and TA for African Americans program is to ensure African American consumers receive accurate diagnosis and appropriate treatment for mental health conditions. The Training and TA program will engage medication prescribers and assessment staff and provide them with the education and tools needed to provide appropriate care for the priority population. The Training and TA program will assist mental health providers in:
   - Accurate diagnosis, treatment, and healing practices for African American communities
   - Providing technical assistance and support to mental health providers in better serving African American communities
   - Recognizing racial bias and the impact on diagnostic and treatment decisions for African Americans across the age span
   - Increasing understanding of differential medication prescription of African Americans across the age span
   - Determining dosage needs and managing side effects specifically as the client ages
   - Understanding the role of culture in symptom presentation, expression, and alternative healing practices
   - Recognizing and working with strengths and protective factors
   - Collaborating with physical health care and substance abuse treatment providers to address co-occurring conditions as the client ages.

2. **OESD 26B African American Reentry Mental Health Services**

   The Request for Proposal (RFP) would be released in October 2018. The overarching goal of the African American Reentry Mental Health Program is to reduce recidivism through the provision of culturally affirming mental health and support services to African American adults with SMI in North and Central County who have a history of involvement in the criminal justice system. Services will be provided to accomplish the following goals:
   - Address stressors impacting clients in order to enhance their mental and emotional wellbeing;
   - Connect clients immediately to essential needs;
   - Connect clients with short- and long-term support services;
   - Reduce hospitalization, incarceration, and other emergency events.

BHCS will contract with one agency to provide the following services to the priority population:

- Mental Health Services

- Case Management/ Brokerage
- Crisis Intervention

The awarded Contractor must maintain a minimum client caseload of 20 clients at any point in time. The awarded Contractor will provide services to a minimum of 30 clients annually.

3. OESD 26C Housing & Employment Navigation Services at MHSA Funded Housing Sites

The awarded program will provide site-based emotional/mental health supportive services in permanent supportive housing sites and subsidized licensed board and cares throughout Alameda County. The Request for Proposal (RFP) is in development and will be released in FY 18/19.

A. COMMUNITY SERVICES and SUPPORTS (CSS) PROGRAM SUMMARIES

OESD 27. In Home Outreach Team (IHOT)
Providers: STARS, La Familia, Bonita House, ABODE Services

Program Description:
The In-Home Outreach Team (IHOT) provides outreach and engagement services to adults with untreated mental illness, with the intention of connecting them with psychiatric care and other community supports. Each IHOT team consists of: a clinical lead, a licensed eligible clinician, two peer advocates, and one family advocate enabling them to have multiple and varied perspectives with which to relate to the participants and their families. This unique factor helps with finding new ways to engage folks otherwise considered resistant or reluctant to engaging in mental health services. IHOT visits participants in their home, hospitals, jails, and in the community to encourage them to engage in mental health treatment. Their goal is to reduce the impact of untreated mental illness in these adults and provide support to their families. The intention of referral and linkage is to help prevent an increase in symptoms, added impairments, or need for more hospitalizations. They schedule appointments with participants, family members, friends, and other providers. They also help make connections to community resources.

Target population:
IHOT serves adults (ages 18-59) with severe mental illness, who are not currently engaged in mental health treatment or have become disengaged, who are considered resistant or reluctant to participating voluntarily and present with a variety of barriers that prevent them from connecting to mental health services and other community resources. IHOT serves adults throughout Alameda County; STARS TAY IHOT Program focus on transitional age youth (TAY) throughout Alameda County.

FY 2017-18 Outcomes

Number of unique consumers/ clients served: 201

FY 2017/18 Impact

IHOT assists client's in linking with services that are most matched to their needs, helping the families and community as a whole. They have linked clients and their families to a variety of resources and services, including: Level 1 Team Services, Full Service Partnerships, chemical dependency treatment programs, shelter. Their linkage has also helped problem solving barriers to accessing these resources clients need such as assistance with Social Security Income, obtaining health insurance, ID cards or Social Security Cards. Perhaps the greatest impact that IHOT has had in our system is to point out areas that our mental health system that could be improved. IHOT tries to fill in the gaps in services and smooth over the difficulties for connecting to community resources (see below for the FY 2017/18 Challenges section).

Consumer / Family Story: A client diagnosed with schizophrenia, paranoid type was disengaged from his service provider, who reached out to IHOT for support. He was homeless and the case manager was unable to contact the client. The Family Advocate reached out to the client's grandmother and both the Peer Advocate and Family Advocate developed a relationship with her, eventually collaborating with the grandmother to arrange a meeting with the client. IHOT staff sought client out, looking for him 2 to 3 times a week in the community, including at a charitable dining room and a local homeless shelter, in order to meet with him. The IHOT Team also aided the client by taking him to Sausal Creek Outpatient Clinic for medication. IHOT worked with the client to understand his needs and wants and organized a

meeting with his assigned service provider, so that the client could express them to his case manager. As this client frequently lost his phone, IHOT would regularly call the case manager with the client during meetings. The client gradually became more engaged with his case manager and started receiving psychiatric services provided by the assigned provider. The case manager found the client appropriate housing and IHOT terminated after a final meeting with the client at his Board and Care facility. This client and his family benefitted from IHOT's ability to provide frequent and consistent outreach that the assigned MH service teams are often not able to provide, due to some of the constraints placed on them.

FY 2017/18 Challenges

- Homelessness, Lack of Housing Resources
- Substance use, difficulty communicating with SUD providers
- Lack of family support for the clients, and lack of supports for families who are connected to clients
- Lack of contact information for client – not being able to locate them
- Trauma and client and family distrust of the system
- Acuity of symptoms, difficulty collaborating with law enforcement when wanting to initiate welfare checks and 5150 evaluations.
- Non-MediCal insurance of clients when referred

FY 2018/19 Projections

Each of the IHOT programs are slightly different but all are able to link families to ongoing supports such as to the Family Education and Resource Center. Two programs, ABODE & La Familia have additionally implemented family support groups on site.

A. COMMUNITY SERVICES and SUPPORTS (CSS) PROGRAM SUMMARIES

OESD 30. Success At Generating Empowerment (SAGE)
Provider: Bay Area Community Services

Program Description:
The Success At Generating Empowerment (SAGE) Program is designed to serve individuals who are in the process of obtaining Social Security Income (SSI) for their qualifying behavioral health (and other disabilities) and who need ongoing clinical care coordination and support as they navigate the challenging bureaucracy while they are managing symptoms related to a behavioral health disorder. Individuals receive assessment, person-centered treatment planning with goals they want to work on, and ongoing counseling, clinical care coordination, linkage, and peer support. As individuals are awarded SSI benefits, they become stable and effective at managing their own lives. Individuals are then linked with ongoing natural and community-based supports for ongoing support. The program has a multidisciplinary staffing model that includes 50% clinical care coordinators and 50% peer counselors – people with their own lived experiences that can walk alongside someone to navigate the challenges of the system.

Target population:
SAGE serve adults (ages 18+) who have a qualifying behavioral health diagnosis and are in the process of obtaining SSI benefits through local legal advocacy firms, Homeless Advocacy Center (HAC) and Bay Area Legal Aid (BALA). All participants live in extreme poverty, at or under 10% Area Median Income (AMI). Many individuals are exiting jails or hospitals. The majority of individuals are homeless.

FY 2017-18 Outcomes

Number of unique consumers/ clients served: 285

FY 2017/18 Impact

The SAGE Program has been instrumental in helping individuals work through massive bureaucracies by supporting them with all activities of daily living and care coordination needs – from signing up for emergency benefits to getting key documents like birth certificates and IDs to access other benefits. Extensive support with accessing affordable housing, linkages to primary health, specialists, employment supports, and more has allowed individuals who otherwise would be lost in the system stay connected until they win their entitled benefits cases. When participants are awarded SSI, they are then transitioned to community natural supports or ongoing services based on service need.

Participant's Story

A consumer suffered from mental and physical health ailments when she first met with her case manager. She had experienced a long period of challenges having lost all four of her children to gun violence in the East Bay. Additionally, the trauma she experienced in early childhood made it hard for her to connect with others resulting in isolation and loneliness. During her engagement with SAGE, the participant was connected to medical, dental, and psychiatric care. She also started seeing a therapist to help her with her trauma and grief. To help her with daily activities, she was connected to an in-home health provider. Within a year of entering the SAGE program, she was awarded SSI which has had immeasurable positive impact on her life. As a result, she has been able to maintain her housing and has told her case manager that she now feels happier, healthier, and financially independent. She has also made new friends and reconnected with her family ending her long period of loneliness and

isolation. Today, she spends time at her favorite Wellness Center – Towne House – where she socializes, cooks with peers, attends a healthy eating group, and sees her doctor for her psychiatric needs.

FY 2017/18 Challenges:

The program has an extremely low barrier model that utilizes a harm reduction approach. Many new participants that enroll are homeless and are immediately lost to the system due to housing insecurity, no ability to contact them, etc. Therefore, the program has enrolled participants who are lost (in the bureaucracy) and not easily engaged.

FY 2018/19 Projections

The program is busy with high demand and does not anticipate any program or model changes.

OESD 31. Older Adult Service Team

Provider: Family Service Agency of San Francisco (FSA)

Program Description:

The Older Adult Service Team will support client recovery through a holistic and strength-based approach that considers the overall bio-psycho-social needs of older adult clients. Over twelve percent of the consumers are sixty or older. With a significant number of older adults needing this level of service, creating a team to focus on the unique needs of the older adult population is a priority. Service Teams are multi-disciplinary and coordinate community-based services to provide individually customized mental health care for people experiencing frequent setbacks or persistent challenges to their recovery. The overarching goal is for clients to attain a level of autonomy within the community of their choosing.

Target population:

The Older Adult Service Team will serve an average of 60 clients per month delivering an average of five hours of outpatient service to each client per month. In addition, provider will provide the following deliverables:

- 85% clients will receive two or more visits within 30 days of beginning services
- 85% of clients will receive four or more visits within 60 days of beginning services
- 85% of clients will remain engaged in the program after six months of services

FY 2017/18 Outcomes

BHCS conducted the RFP process beginning early 2017 and selected Family Service Agency of San Francisco (FSA) as provider for the Older Adult Service OESD 31 Older Adult Service Team.

FY 2018/19 Projections

Program implementation began in April 2018. The description of the program above remains current. The first phase of the program was start-up; approximately 60 clients will be admitted to the program by October 2018. The program is expected to admit total of 90 clients. More information will be provided in the next Plan Update.

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

Alameda County has implemented a variety and continuum 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 implement services that promote wellness, foster health and emphasize strategies to reduce these seven 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.

As Alameda County works to fully incorporate the new Mental Health Services Oversight and Accountability (MHSOAC) approved Prevention and Early Intervention Regulations into its services we will focus our future evaluation efforts on mitigating the above seven negative outcomes.

California's historic commitment to prevention and early intervention through Prop 63 moves the mental health system towards a "help-first" instead of a "fail first" strategy. PEI identifies individuals at risk of or indicating early signs of mental illness or emotional disturbance and links them to treatment and other resources.[2]

Alameda County's PEI programs create partnerships with unserved and underserved ethnic and linguistically isolated communities, schools, the justice system, primary care and a wide range of social, wellness and spiritual support services and local community groups. In addition to these partnerships, the county has also placed these preventative and early intervention services in convenient locations where people go for other routine health care, wellness, leisure, educational, recreational, faith and spiritual healing and other activities which promote social connectedness and individual, family and community functioning. The MHSA specifies that all funded PEI Programs must include the following strategies:

- **Outreach** to families, employers, primary care health care providers, and others to recognize the early signs of potentially severe and disabling mental illness;

- **Access and linkage** to medically necessary care…as early in the onset of these conditions as 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 INTERVENTION (PEI) PROGRAM SUMMARIES

STATE DEFINED PREVENTION AND EARLY INTERVENTION PROGRAMS

PREVENTION

- Activities that reduce risk factors for developing a potentially serious mental illness and to build protective factors.
- Activities that improve mental health for individuals/groups whose risk of developing a potentially serious mental illness is greater than average.
- Prevention services may include relapse prevention for individuals in recovery from a serious mental illness and population health prevention services.

EARLY INTERVENTION

- Provide mental health treatment, including relapse prevention, intended to promote recovery and related functional outcomes for a mental illness early in its emergence.
- Length of services not to exceed 18 months. If the individual is identified living with Severe Mental Illness (SMI) with psychotic features, up to four years of service can be allowed. This program can be combined with the Prevention Program.

OUTREACH

- Processes that engage and/or train potential responders about ways to recognize and respond to early signs of potentially severe and disabling mental illness.
- Supports for individuals who can identify early signs of severe and disabling mental illness to provide support, and/or refer individuals to treatment or other mental health services.
- Outreach may include reaching out to individuals with signs and symptoms of a mental illness, so they can respond to their own symptoms

STIGMA & DISCRIMINATION REDUCTION

- Activities that reduce negative feelings, attitudes, beliefs, perceptions and/or discrimination related to being diagnosed with a mental illness or to seeking mental health services.
- Activities that increase acceptance, dignity, inclusion, and equity for individuals with mental illness and members of their families.
- Programs include approaches that are culturally congruent with the values of the populations for whom changes are intended.

ACCESS & LINKAGE TO TX

- Set of related activities to connect children, adults, and seniors with severe mental illness to medically necessary care and treatment as early in the onset as practicable.
- These types of programs can include, but are not limited to, screening, assessment, referral, telephone help lines, and mobile response.
- Includes targeted access and linkage activities for cultural populations.

SUICIDE PREVENTION

- Organized activities that the County undertakes to prevent suicide as a consequence of mental illness without focus on or intended outcomes for at-risk individuals.
- These types of focused activities may be part of a prevention program or an early intervention program.
- This program is optional and includes, but is not limited to, strategies such as information campaigns, survivor-informed models, screenings, training, and education.

Prevention Program
PEI Data Report FY 17/18

As required for each Prevention Program:

MHSA program Number: **PEI 1A**

Program Name: **Blue Skies Mental Wellness Team**

Program Description:

The Blue Skies Mental Wellness Team (BSMWT) provides families participating in home visitation and family support ACPHD-MPCAH programs with clinical case management, brief therapy and case consultation-case review services. This ACPHD-MPCAH program provides support services for Perinatal Mood Disorders and other emerging or diagnosed mental health concerns to provide stabilization, referrals and resources to families.

Number of **unduplicated** individuals served in the preceding fiscal year (FY 16/17): 91 (parent child dyads)

Number of individual family members (this number will be included in your total above): 101 (parent child dyads) = 79 parents/caregivers [ages 16-43] and 22 children [ages 0-3]

Demographics

Report disaggregate numbers served, number of potential responders engaged (for agencies conducting outreach), and number of referrals for treatment and other services for the following categories:

Age Group (Unduplicated)

Children/Youth (0---15)	22
Transition Age Youth (16---25)	20
Adult (26---59)	59
Older Adult (60+)	0
Declined to Answer	0
Total	**101**

Race (Unduplicated)

American Indian or Alaska Native	0
Asian	2
Black or African American	56
Native Hawaiian or other Pacific Islander	0
White [Includes Hispanic and Non-Hispanic]	31
Other	0
More than one race	0
Declined to Answer	12
Total	**101**

Ethnicity (Cultural Heritage)

Hispanic or Latino as follows:	
Caribbean	0
Central American	6
Mexican/Mexican-American/Chicano	14
Puerto Rican	0
South American	0
Other	5
Declined to Answer	12
Non-Hispanic or Non-Latino as follows:	
African [Black or African American, Non-Hispanic]	53
Asian Indian/South Asian	0
Cambodian	0
Chinese	1
Eastern European	0
European	0
Filipino	1
Japanese	0
Korean	0
Middle Eastern	1
Vietnamese	0
Other [White, Non-Hispanic]	8
More than one ethnicity	0
Declined to Answer	0
Total	**101**

Primary Languages

English	57
Spanish	21
Chinese Dialect	0
Japanese	0
Filipino Dialect	0
Vietnamese	0
Laotian	0
Cambodian	0
Sign ASL	0
Other Non---English [Mam]	1
Korean	0
Russian	0
Polish	0
German	0
Italian	0
Mien	0
Hmong	0
Turkish	0
Hebrew	0

French	0
Cantonese	0
Mandarin	0
Portuguese	0
Armenian	0
Arabic	0
Samoan	0
Thai	0
Farsi	0
Other Sign	0
Other Chinese Dialects	0
Ilocano	0
Total	**79**

Sexual Orientation

Gay or Lesbian	0
Heterosexual or Straight	0
Bisexual	0
Questioning or unsure of sexual orientation	0
Queer	0
Another sexual orientation	0
Decline to Answer	0
Unknown	79
Total	**79**

Disability

Yes	1
Communication Domain:	
Difficulty Seeing	0
Difficulty hearing, or having speech understood	0
Other (specify)	0
Mental Domain	0
Physical/Mobility Domain	1
Chronic Health Condition	0
Other	0
No	98
Decline to Answer	2
Total	**101**

Veteran Status

Yes	0
No	0
Decline to Answer	0
Unknown	79
Total	**79**

Gender

Assigned sex at birth:	
Male	0
Female	0
Decline to Answer	0
Unknown	79
Current Gender Identity:	
Male	13
Female	87
Transgender	0
Genderqueer	0
Questioning or Unsure of Gender Identity	0
Another Gender Identity	0
Decline to Answer	1
Total	**101**

Number of individuals with SMI or SED referred to BHCS treatment system (includes county and CBO providers): 130

List type(s) of treatment referred to:

Agencies	**# Clients Referred**
ACCESS	22
Family Paths Hotline	20
Crisis Support Services	18
Early Head Start Program	5
Private Practice	5
Victim of Crime Alameda County	4
Help A Mother Out	3
Through the Looking Glass	3
Other	3
4 C's	2
BANANAS	2
Building Hope	2
Cal Fresh	2
CAPE Early Interventions Program	2
East Bay Integrative Pregnancy Program	2
La Casa Del Sol	2
San Leandro Library Play Group	2
Tiburcio Vasquez Health Center	2
Acts Cyrene Apartments Oakland Housing Authority and the City of Oakland.	1
Alameda County Health Care Services Agency Public Health Nursing	1
Alexandra Bachanm Immigration attorney in Oakland	1
Blue Skies Mental Health Family Fun Day	1
Bonita House	1
Children's Hospital in Oakland.	1

City of Berkeley Vital records	1
Community association for Pre-school Education 0-8 Program	1
DMV	1
Family Justice Center in Oakland.	1
FESCO Shelter Program.	1
First 5 San Mateo County	1
For Rapid Response and Immigration Legal Services Flyer	1
HECHO Housing in Hayward	1
John George Hospital	1
John Muir Behavioral Health Center	1
Medical	1
Mental Health Advocate Program	1
MPCAH Safeway Card	1
Neuropsychiatry Services at Highland Hospital	1
Newark Medical Center	1
Oakland Adult Education	1
OBG Department at Highland Hospital	1
Pediatric Unit at Highland Hospital	1
Pediatrician at Southland Health Pack Center	1
Salvation Army Shelter	1
Shepherd's Gate DV Shelter	1
Southland Health Pack	1
WIC	1
Total	**130**

Number of individuals who followed through on referral & engaged in treatment: 74
Average duration of untreated mental illness: 2.1 days Standard Deviation: 6.98
Average time between referral and participation in treatment: 2.1 days Standard Deviation: 6.9

Improving Timely Access to Services for Underserved Populations Strategy (Required):

Target population: Early Intervention Programs, MPCAH Home Visiting Programs& Parents with young children ages 0-5
Number of referrals to a **Prevention** program: 9
Number of referrals to an **Early Intervention** program: 19
Number of individuals followed through on referral & engaged in early intervention treatment services: NA

Average time between referral and participation in treatment: NA Standard Deviation: NA

And/Or:

Number of referrals to **BHCS treatment system (beyond early onset): 22**
Number of individuals followed through on referral & engaged in treatment: NA
Average time between referral and participation in treatment: NA Standard Deviation: NA

As required for each Prevention Program:

Implementation Challenges:

Blue Skies Mental Wellness Team (BSMWT) continues to seek relevant training options for adult/parenting consultation model enhancements (most models focus on Early Childhood Child Care Consultation).
Lack of updates provided on MAA fiscal reporting and funding for growth implementation strategies support.
Lack of Program Assistant or Administrative Assistance for Clerical challenges and administrative challenges needed to support program.

Success:

For (2) years BSMWT has continued to provide consistent mental health/consultation services to ACPHD Home Visiting system of care. We have consulted and accepted program referrals for mental health supports to (6) public health home visiting programs providing reflective consultation and case review to the Black Infant Health Program, Fatherhood Program, Women's Health Promotion, Family Health Promotion, Nurse Family Partnership and the Healthy Families American Programs. We have maintained consistent staffing with (2) BHC's II, and 1 half-time mental health clinicians funded by TAP and ACHSI support (position will be discontinued when staff members resigns to complete her pre-Doc program requirements) along with a MPCAH half-time Program therapist partially assigned to the BSMWT. We have continued to offer our department quarterly transformational healing circle events without dedicated funding and have continued to increase our program services/client numbers.

Lessons Learned:

Without a dedicated program assistant or program specialist it is difficult to devote much time toward program development to create and design needed elements of change to support program model. It is also more difficult to maintain and enforce quality improvement measures to support the work of clinicians to ensure that "best practice" standards are maintained to ensure program efficiency. We would like to engage with thought partners on ways to bring in additional staff members **and funding** for other components of program enhancement for Blue Skies Mental Wellness Team including; a family therapy clinician and a developmental/therapist specialist to add to our team. We have many requests for family therapy and for couples/co-parenting support work to which we are unable to respond.

Relevant Examples of Success/Impact:

We have engaged with a newly positioned staff member from FHS, A Registered Addiction Specialist/Family Support Case Worker from MPCAH-Family Support Services. This staff member is engaging in working with clients with substance abuse challenges and addiction needs by providing supportive counseling and referral resources. She has become a valued member of our Mental Wellness Team and is additionally offering brief trainings for MPCAH staff on substance abuse related concerns. The MWT has continued to offer monthly Case Review and Consultation meetings to (6) Home Visiting programs listed above, providing a model where case reflection, resource sharing, case discussion and trauma informed check in's and processes are shared among program participants. We have offered a Mom-to-Mom Depression Group twice this calendar year, offering parents referred to us with depressive symptoms or diagnosis an 8-week cognitive behavioral group curriculum where clients review behavioral supports. We continue to see an increase in consultation request and engagement with MPCAH program staff members and they appear to be recognizing the "value add" of having an in-house team of mental health specialist to consult with to discuss challenging clients with mental health concerns and complex psycho-social needs. We have provided (5) home visiting programs with an overview in-service on the importance of utilizing the Edinburg Depression Screening Tool (EPDS). MPCAH home visiting programs continue to utilize the EPDS screener as a mental health prevention/awareness tool to screen for depression and our department has implemented the use of EPDS as a standard protocol for all home visiting programs. This has been led by implementation efforts by the MWT Program Manager and a committee workgroup. Lastly, we continue to support the Family Health Services-MPCAH Unit with quarterly Transformational Healing Circles promoting trauma informed strategies for wellness. The events are well attended and enjoyed.

Additional Information:

In this section, please include the number of clients and/or contacts you estimate to serve in:
FY 17/18: 101
FY 18/19: 110
FY 19/20: 120

Any changes you intend to make to your program over the next three fiscal years:
We plan to utilize the BHCS website to recruit prospective graduate student interns to work and train with our program in the near future. The application process for this support has been completed and we would like to enhance the process of recruiting more interns in 2018-2019. We also seek to obtain funding from MHSA or BHC to add an additional F/T BHC to the team. Since we will no longer have the funding from ACPHD to hire a TAP half-time clinician, We would like to gain insights on how to partner with additional BHC program leadership to discuss the out-stationing of a clinician to join our team in public health in offering Family Therapy options for MPCAH clients along with gaining the ability to hire a F/T BHC II to support our increased referrals and case review consultation processes. We will seek funding partners to engage in thinking about ways to continue our work in providing transformational healing circles as a continued trauma informed support for our department's workforce and continue our work to offer comprehensive case management and mental health supports in home visiting.

PREVENTION & EARLY INVERVENTION PROGRAM SUMMARIES
UNDERSERVED ETHNIC LANGUAGE POPULATION (UELP) PROGRAMS

The UELP programs (PEI #5-8) were designed to provide services to historically unserved and underserved populations, which the State defines 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) Preventive Counseling 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 and program promotion activities; prevention visits to prepare for and to conclude a series of counseling sessions as needed 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 17/18 the data show that the UELP providers in total produced:

- 5,780 prevention events;
- 37,136 people served at these prevention events; (duplicated count), and
- 759 unique clients served through early intervention services.

Alameda County Behavioral Health Care Services currently uses a community defined Health and Wellness survey, which includes quality of life and outcome indicators. The survey is administered 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 wellness;
- Improving access to services and resource;
- Transforming mental health services, and
- Increasing workforce and leadership development.

A summary of key findings, based on each of the domains above, from the administration of the FY 17/18 survey (of 272 participants) and the FGs/KIIs shows that *in connection with receiving UELP services*:

Forming and Strengthening Identity

After participating in these services, UELP participants are better equipped to handle problematic situations and crises. Survey data shows that UELP participants have strengthened their identity and improved their self-efficacy. Eighty-eight percent of survey respondents receiving Prevention services reported that they were better able to deal with a crisis. Ninety-three percent of survey respondents receiving Prevention services reported feeling better about themselves.

- Changing Individual Knowledge and Perception of Mental Health Services

The data shows that respondents have a firm understanding of how different types of moods impact their mental, emotional and overall health. The data also show a shift in the perception of mental health in Prevention services, suggesting a reduction in internalized stigma about the experience of mental health challenges. Ninety-three percent of survey respondents reported having a stronger belief that most people with mental health experiences can grow, change and recover.

- Building Community Wellness

UELP providers have successfully created opportunities for their members to build new friendships and support systems within their programs. Of the respondents that received Prevention services, Ninety-three percent of survey respondents said that they have people with whom they can do enjoyable things. Ninety-six percent of respondents reported knowing that there are people who will listen and support them whenever they need someone to talk to.

- Connecting Individuals and Family with their Culture

UELP services aim to bolster the connection clients have with their culture by utilizing cultural norms as a bridge to service provision. Examples include using cultural practices and observances to ground program activities. Ninety-five percent of survey respondents receiving Prevention services reported feeling more connected to their culture and community.

- Improving Access to Services and Resources

Members of monolingual or LEP (Limited English Proficiency) populations may experience challenges navigating behavioral healthcare systems and accessing services, information and resources, particularly when they are in crisis. These barriers can exacerbate stress, anxiety, isolation, depression, stigma and other mental health concerns. With the assistance of UELP services, it appears that participants are more successful at navigating healthcare systems to obtain needed services and resources. Ninety-five percent of survey respondents receiving Prevention services reported becoming more effective in finding the resources that they need or their family needs.

- Transforming Mental Health Services

Agencies that deliver UELP services are determined to provide transformative mental health services in which one size does not fit all. This approach emphasizes the use of culturally-congruent mental health methods. The data shows that respondents are satisfied with the services they receive. They report that they are treated well and that they would recommend the services to friends or family members. Ninety-three percent of clients reported that staff was sensitive to their cultural background. Ninety-nine percent said that UELP staff provided them with the information they needed to help manage their problems.

- Remaining Challenges

Although these UELP services significantly and positively impact the clients being served, there are still multiple client challenges. Several of the challenges that surfaced during the FG/KII that are extremely worthy of highlighting include:

Across most of the ethnic groups involved in this process, there is still a large problem with ***community/family stigma*** in their cultures. The lack of available and affordable ***housing*** is another significant issue that surfaced

during the sessions. Staff from the Latino community reported that they see an increased number of cases of anxiety disorders in people from South America related to the impacts of new immigration laws and policies and approaches by the current federal administration. According to staff, clients appear to be exhibiting fear around issues such as immigration, family separation, assimilation and poverty.

Improving Access to Services and Resources

Connecting clients to resources is a vital aspect of UELP programming. The majority of participants have become more successful at navigating the BHCS system to obtain the services and resources they need.

Additional Findings

The UELP providers administer services to several unique and distinct populations in Alameda County. After reviewing four years of data, it is evident that the UELP programming is an optimal design for improving the health and wellness of these often marginalized populations, by meeting their cultural, language, mental and emotional needs. UELP is transforming the way mental health services are provided to underserved populations in Alameda County.

The data suggests that clients are benefiting from the mental health and emotional support they have received. Although they are showing improvement, it is also evident that they still have needs and want more help and support, specifically in the areas of mental health and emotional support. Clients are incredibly thankful for their UELP programs. They love the services and want more of them. Without the support of UELP, they would have been adversely impacted. Respondents reported that without these services they would not have increased their knowledge of mental health, would not have had the information needed to secure resources, would have been without the emotional support they so desperately need, and would have made a greater number of decisions that would have negatively affected their lives.

The most compelling data this year came from the *PC* respondents. This is the first annual evaluation report to include a panel analysis of the community health assessment that demonstrates change over time specifically for clients that receive *PC* services. This is meaningful because *PC* clients are a subset of participants that are at higher risk and already showing signs of having a mental illness. They enter their programs with higher needs and require more intensive services.

The majority of *PC* respondents reported either the same score or an improved score for their level of crisis, health status and level of activity. Very few respondents reported a worse score. This data suggests that services are helping to mitigate crises and challenges that clients may be facing, however, they are still in need of additional services. Data from the cohort analysis shows that clients are still reporting crises and poor health but at lower percentages. This is a dramatic improvement from previous years, but this area still requires more research.

Prevention Program
PEI Data Report FY 17/18

As required for each Prevention Program:

MHSA program Number: **PEI 5**

Program Name: **La Clinica de La Raza, Inc. (La Clinica) - Outreach, Education & Consultation for Latino Community**

Program Description:

Cultura y Bienestar (CyB), La Clinica's UELP MSHA Prevention and Early Intervention program, serves Latinos throughout Alameda County through a three-agency collaboration. La Clinica de La Raza, the lead agency, serves Latinos in Northern Alameda County, La Familia Counseling Services serves the central region, La Familia's East Bay serves the east county region, and Tiburcio Vasquez Health Center serves the southern region of Alameda County.

Number of **unduplicated** individuals served in the fiscal year (FY 17/18): 18,629

Number of individual family members (this number will be included in your total above): unknown

Demographics

Report disaggregate numbers served, number of potential responders engaged (for agencies conducting outreach), and number of referrals for treatment and other services for the following categories:

Age Group (Unduplicated)

Children/Youth (0---15)	4,310
Transition Age Youth (16---25)	2,875
Adult (26---59)	8,307
Older Adult (60+)	1,987
Declined to Answer	1,150

Race (Unduplicated)

American Indian or Alaska Native	4
Asian	613
Black or African American	533
Native Hawaiian or other Pacific Islander	0
White	1,248
Other	13,030
More than one race	0
Declined to Answer	1,519

Ethnicity (Cultural Heritage)

Hispanic or Latino as follows:	
Caribbean	16
Central American	1,360
Mexican/Mexican---American/Chicano	8,293
Puerto Rican	59
South American	174
Other	3,133
Declined to Answer	
Non---Hispanic or Non---Latino as follows:	
African	
Asian Indian/South Asian	
Cambodian	
Chinese	
Eastern European	
European	
Filipino	
Japanese	
Korean	
Middle Eastern	
Vietnamese	
Other	
More than one ethnicity	
Declined to Answer	

Primary Languages

English	4,840
Spanish	13,385
Chinese Dialect	
Japanese	
Filipino Dialect	
Vietnamese	
Laotian	
Cambodian	
Sign ASL	
Other Non---English	3,898
Korean	
Russian	
Polish	
German	
Italian	
Mien	
Hmong	
Turkish	
Hebrew	
French	
Cantonese	

Mandarin	
Portuguese	
Armenian	
Arabic	
Samoan	
Thai	
Farsi	
Other Sign	
Other Chinese Dialects	
Ilocano	

Sexual Orientation

Gay or Lesbian	16
Heterosexual or Straight	56,712
Bisexual	8
Questioning or unsure of sexual orientation	1
Queer	1
Another sexual orientation	11
Decline to Answer	12,915

Disability

Yes	490
Communication Domain:	
Difficulty Seeing	8
Difficulty hearing, or having speech understood	8
Other (specify)	
Mental Domain	13
Physical/Mobility Domain	168
Chronic Health Condition	271
Other	
No	5,769
Decline to Answer	12,370

Veteran Status

Yes	85
No	8,625
Decline to Answer	9,919

Gender

Assigned sex at birth:	
Male	5,583
Female	11,539
Decline to Answer	1,504
Current Gender Identity:	
Male	
Female	
Transgender	1
Genderqueer	
Questioning or Unsure of Gender Identity	
Another Gender Identity	
Decline to Answer	1,503

Total number of potential responders (outreach audience): 2,249

List type of setting(s) in which the potential responders were engaged and the type(s) of potential responders engaged in each setting:

Type of Setting(s) (ex: school, community center)	**Type(s) of Potential Responders** (ex: principals, teachers, parents, nurses, peers) Separate each type of responder with a comma.
Consultations One-to-one outreach (phone call or in-person face to face) Prevention Visit Psycho-education workshops Classes for community members Support Group Traditional healing workshop Training for professionals/leaders	With family members, community leaders, community members, parents, professionals,

Access and Linkage to Treatment <u>Strategy</u> (Required):

Number of individuals with SMI or SED referred to BHCS treatment system (includes county and CBO providers): unknown

List type(s) of treatment referred to:

All staff are expected to provide outreach at community events, and various other locations where the Latino community congregates in order to provide information on mental health and the services that the program provides. Additionally once CyB engages clients, staff complete referral forms so that the coordinator for the program can follow up and contact each client to see if they have followed through on the referral and in order to make additional referrals as necessary. Furthermore, the CyB Mental Health Specialists, promote program expansion and usage by meeting with community leaders and their staff to provide workshops and consultation support.

Improving Timely Access to Services for Underserved Populations Strategy (Required):

Target population: La Clinica de La Raza, the lead agency, serves Latinos in Northern Alameda County, La Familia Counseling Services serves the central region, La Familia's east bay serves the east county region, and Tiburcio Vasquez Health Center serves the southern region of Alameda County.

Number of referrals to a **Prevention** program: unknown

Number of referrals to an **Early Intervention** program: unknown
Number of individuals followed through on referral & engaged in early intervention treatment services: unknown
Average time between referral and participation in treatment: unknown Standard Deviation: unknown

Because CyB is well known and recognized for the program's workshops and cultural events, parents, students and teachers have requested CyB to provide more workshops/events that address topics related to families (e.g. how to communicate with your children and how to communicate with your parents; how to build healthy relationship in the family). These cultural events have been received very well by the CyB community and the program gets asked to participate in more events that deal with the topic of families.

CyB has excellent relationships and collaborations with Alameda County schools, head start programs, charter schools, school based health centers, colleges, migrant education programs, faith and community based organizations such as Covenant House, FERC, Mujeres Unidas y Activas, 67 Suenos, La Red Latina, St. Elizabeth's, the Unity Council, 10x10 Campaign, El Chante, CODA, Native American Health Center, BHCS programs/projects such as school based EPSTD services, COST meetings, Early Learning Network (ELN) and other prevention programs, The Stigma and Discrimination Reduction Campaign, Alameda County New Comer Immigrant and Refugee Community Center (Planning Committee). CyB staff continue to work with Casa CHE, La Clinica's prevention program, which serves the LGBTQQI community and at risk youth. CyB staff attends school open houses, health fairs, community events (Cinco de Mayo, Dia de Los Muertos, Mercado de La Noche, Church events) and any other events CyB may be invited to.

And/Or:

Number of referrals to **BHCS treatment system (beyond early onset):** unknown
Number of individuals followed through on referral & engaged in treatment: unknown
Average time between referral and participation in treatment: unknown Standard Deviation: unknown

As required for each Prevention Program:

Implementation Challenges:

Two of the three challenges that were highlighted in FY 16 -17 continue to be challenges in FY 17-18. First, program service demands continue to surpass staff allocated time which results in limiting some workshops and presentations due to lack of capacity. The demand for one-on-one Prevention and Early Intervention visits and workshops for adult Latinos exceeds staff availability. This is particularly true for staff serving the adult/senior community. Fortunately, CyB has better been able to meet this demand due to the California Reducing Disparities Project grant, which has allowed the Collaborative to increase FTE of part-time staff.
Additionally, CyB continues to have challenges referring clients to other mental health programs and services due to both issues of stigma and long waiting lists for mental health services in Spanish. Waiting lists are counter-productive because CyB clients begin to lose interest, their hesitance increases and they tend not to follow through if services are not immediately available.
A third challenge is replacing staff once they leave. CyB had a total of six vacancies during FY 17/18. All positions have been filled and we are fully staffed once again.
Lastly, CyB is working on standardizing all program curricula and assuring that all CyB staff is providing the same trainings despite agency affiliation. This will be an area of continued training in FY 18-19 to maximize accuracy and ensure that all activities are presented in a standardized format.

Success:

Fiscal year 17-18 brought many major successes for CyB. Firstly, CyB was chosen to present at the Annual American Public Health Association Conference in San Diego, California on November 10th-14th, 2018. The focus of the presentation will be on how Latinos living in the United States have poorer mental health status when compared to their counterparts in their country of origin. This is called the Latino or Immigrant Paradox, which refers to the fact that Latinos often become less healthy both mentally and physically with greater levels of acculturation to the dominant culture in the United States. This trend is also noted in Alameda County, CA where Latinos are four times less likely than African Americans and more than two times less likely than Caucasians to be served in the mental health system. CyB's presentation will describe the CyB program, which uses a culturally based, non-stigmatizing Latino-focused strategy that draws upon and reinforces existing cultural strengths and practices to facilitate mental health healing, create wellness, and build resiliency within the Latino community. The program uses four key strategies and methods: Peer-to-peer education, Mental Health Training/Consultation, Traditional Healing or Cultural Events, and Referral and Linkage to services.

Lessons Learned:

A key lesson learned is that teamwork is a critical aspect of overcoming challenges and meeting our goals successfully, and collaboration is necessary, not optional.

Relevant Examples of Success/Impact:

CyB continues to bridge sacred traditional healing modalities, mental health education
And early intervention by emphasizing the integration of wellness and emotional balance with the use of herbs, meditation, visualization, massage (sobado) techniques, and general curanderismo. CyB has been able to weave the topics of mental health/emotional well-being

Additionally, mental health topics are woven into all of the program's activities, outreach, CBO trainings, individual, couple, family, and consultations with family and community members, as well as the traditional medicine workshops. CyB's model for treating trauma is psycho-educational in nature and the program integrates somatics, and makes referrals to acupuncture treatment. CyB continues to work with partners in order to make presentations to existing health-related groups such as nutrition classes, zumba groups and topics focused on mental health issues associated with stress and fatigue.

Additional Information:

In this section please include the number of clients and/or contacts you estimate to serve in:
FY 18/19:
FY 19/20:

Any changes you intend to make to your program over the next three fiscal years:

CyB's goals include continuing to expand program services into Castro Valley, San Leandro, and San Lorenzo and continue cultivating relationships and alliances in these communities. CyB will reach out more to the LGBTQQI community to promote the CyB program and ask how the program can build trust within this community. This fiscal year (FY), CyB has observed that a large population of women who come to the program feel unappreciated in their lives, don't have a voice, and feel under-valued, isolated, and alone. As a result of this need, CyB will work on a plan to begin a women's group which will focus on building self-esteem, providing education about depression, self-care, and include "temescals" for women.

Prevention Program
PEI Data Report FY 17/18

As required for each Prevention Program:

MHSA program Number: **PEI 6**

Program Name: Asian **Health Services - Outreach, Education & Consultation for Asian Community**

Program Description:

The Prevention & Wellness Program (also known as simply the "Prevention Program") is one of the five prevention and early intervention (PEI) projects funded by Alameda County Behavioral Health Care Services (ACBHCS) addressing the mental health and other needs of underserved and emerging API communities. Our goals are to improve access to culturally competent prevention and early intervention services, reduce stigma attached to mental health services, and strengthen API communities' knowledge of wellness practices and resources. Our services include outreach and education, mental health consultation, and preventative counseling (short term counseling and connection to resources). Our prevention program was contracted to serve the following communities: Burmese, Chin, Chinese, Filipino, Karen, Karenni, Khmer, Korean, Laotian, Japanese, Mien, Thai, and Vietnamese.

Number of **unduplicated** individuals served in the fiscal year (FY 17/18): 4,010
Number of individual family members (this number will be included in your total above): unknown

Demographics

Report disaggregate numbers served, number of potential responders engaged (for agencies conducting outreach), and number of referrals for treatment and other services for the following categories:

Age Group (Unduplicated)

Children/Youth (0---15)	470
Transition Age Youth (16---25)	572
Adult (26---59)	1,962
Older Adult (60+)	969
Declined to Answer	37

Race (Unduplicated)

American Indian or Alaska Native	
Asian	3,361
Black or African American	66
Native Hawaiian or other Pacific Islander	48
White	132
Other	40
More than one race	124
Declined to Answer	124

Ethnicity (Cultural Heritage)

Hispanic or Latino as follows:	
Caribbean	
Central American	
Mexican/Mexican---American/Chicano	
Puerto Rican	
South American	
Other	
Declined to Answer	
Non---Hispanic or Non---Latino as follows:	
African	
Asian Indian/South Asian	44
Cambodian	347
Chinese	1,217
Eastern European	
European	
Filipino	77
Japanese	48
Korean	151
Middle Eastern	
Vietnamese	809
Other	559
More than one ethnicity	
Declined to Answer	

Primary Languages

English	1,677
Spanish	
Chinese Dialect	
Japanese	3
Filipino Dialect	6
Vietnamese	600
Laotian	49
Cambodian	218
Sign ASL	
Other Non---English	266
Korean	101
Russian	
Polish	
German	
Italian	
Mien	223
Hmong	4
Turkish	
Hebrew	
French	
Cantonese	803
Mandarin	48
Portuguese	
Armenian	
Arabic	
Samoan	
Thai	1
Farsi	
Other Sign	
Other Chinese Dialects	
Ilocano	

Sexual Orientation

Gay or Lesbian	18
Heterosexual or Straight	685
Bisexual	2
Questioning or unsure of sexual orientation	58
Queer	8
Another sexual orientation	2
Decline to Answer	3,288

Disability

Yes	447
Communication Domain:	
Difficulty Seeing	6
Difficulty hearing, or having speech understood	4
Other (specify)	6
Mental Domain	380
Physical/Mobility Domain	26
Chronic Health Condition	15
Other	11
No	945
Decline to Answer	2,618

Veteran Status

Yes	4
No	2,205
Decline to Answer	1,801

Gender

Assigned sex at birth:	
Male	1,521
Female	2,460
Decline to Answer	42
Current Gender Identity:	
Male	
Female	
Transgender	4
Genderqueer	
Questioning or Unsure of Gender Identity	
Another Gender Identity	
Decline to Answer	

Total number of potential responders (outreach audience): 4,010

List type of setting(s) in which the potential responders were engaged and the type(s) of potential responders engaged in each setting:

Type of Setting(s) (ex: school, community center)	**Type(s) of Potential Responders** (ex: principals, teachers, parents, nurses, peers) Separate each type of responder with a comma.
Consultations One-to-one outreach (phone call or in-person face to face) Prevention Visit Psycho-education workshops Classes for community members Support Group Traditional healing workshop Training for professionals/leaders	With family members, community leaders, community members, parents, professionals

Access and Linkage to Treatment <u>Strategy</u> (Required):

Number of individuals with SMI or SED referred to BHCS treatment system (includes county and CBO providers): unknown

List type(s) of treatment referred to:

The Prevention Program found "in-reach" activities, or targeting API community members already connected to the larger AHS agency (through other departments and services), to be an effective strategy in encouraging follow-through and positive linkage for referrals. An example of effective in-reach includes our early collaboration with AHS' The Spot youth programs, such as through a monthly "API Youth Collaborative" meeting where potential youth referrals and resources from various AHS programs are discussed and followed up on, as well as the other outreach/consultation activities with The Spot mentioned elsewhere in this report. AHS staff from various departments also have the ease of following up on referrals and encouraging linkage through our direct communication with one another. Other notable examples of in-reach from the year were when Prevention staff went to one of the AHS all-manager meetings to do a short presentation on dynamic mindfulness as a self-care strategy (reaching about 30 AHS employees), and were later invited to demonstrate dynamic mindfulness activities to the larger AHS employee community at one of the bi-annual all-staff meetings (reaching over 400 AHS employees). As other AHS divisions became more acquainted with SMH services and vice versa, the process of referring and linking community members between Prevention Program and other health services, such as dental services, the PLC department, and youth programs became more seamless. When warm hand-offs of referrals between AHS providers and Prevention staff were possible, this furthermore encouraged successful linkage.

Improving Timely Access to Services for Underserved Populations <u>Strategy</u> (Required):

Target population: Our prevention program was contracted to serve the following communities: Burmese, Chin, Chinese, Filipino, Karen, Karenni, Khmer, Korean, Laotian, Japanese, Mien, Thai, and Vietnamese.

Number of referrals to a **Prevention** program: unknown
Number of referrals to an **Early Intervention** program: unknown
Number of individuals followed through on referral & engaged in early intervention treatment services: unknown
Average time between referral and participation in treatment: unknown Standard Deviation: unknown

One of our furthest-reaching partnerships this year was our participation in Alameda County's annual 10 x 10 Wellness Campaign event, "We Move for Health," held at Lake Elizabeth in Fremont in May 2018. As in previous years, our

Prevention Program sent representatives to the campaign's monthly Community Advisory Board meetings, so that we could be involved in the planning and coordination of the event as mental health consultants. Through our outreach and coordination, we also accomplished sending 50 API community members already linked into our services to the all-day event, where they participated in healthy physical activities, learned about other wellness services and resources around the county, and confronted the stigma of mental health by being part of this public effort to raise mental health awareness. Finally, our program hosted one of the many community resource tables at the event. We designed an interactive engagement activity for 10 x 10 attendees who came to our table, where they were able to identify signs of stress and effective ways of coping with stress. We then shared information about our SMH Treatment and Prevention services with attendees. Through this engagement, we reached 98 unique community contacts in Fremont, representing a portion of the county that we have not outreached to often but would like to connect with more.

And/Or:

Number of referrals to **BHCS treatment system (beyond early onset):** unknown
Number of individuals followed through on referral & engaged in treatment: unknown
Average time between referral and participation in treatment: unknown Standard Deviation: unknown

As required for each Prevention Program:

Implementation Challenges:

Our Prevention Program had the challenge of meeting some of our contractual goals for FY 17-18. Prevention staff conducted a total of 155 mental health consultation events throughout the year, when 165 events were expected. Our Preventive Counseling program served 51 unique clients over the course of the year, when 60 unique clients were expected. Finally, we referred 8 unique clients from Preventive Counseling to higher care mental health treatment programs, when 10 unique clients were expected. Several related challenges may partially explain why the program came out slightly under these goals.

We believe that the difficulty in referring 60 unique clients to Preventive Counseling is related to the persistence of mental health stigma in our API communities. Despite our various outreach and recruitment attempts, community members often declined to consent to a formal wellness service. For example, when outreaching to youth at AHS' The Spot, youth seemed to benefit from engaging informally with outreach workers but were hesitant to approach their parents to provide consent to the Preventive Counseling program. Stigma also played a role in our inability to meet 10 client referrals from Preventive Counseling to mental health treatment. Another factor was that there were times when staff wanted to refer Preventive Counseling clients to higher care, but they did not meet the full criteria for a treatment program.

Success:

One of the biggest successes/accomplishments of the past year was the program's development of an "Introduction to Mental Health" presentation/workshop. These presentations empower participants to identify signs of stress and develop healthy coping strategies in order to prevent more serious mental health problems. Staff developed Introduction to Mental Health using knowledge gained at various trainings including Dynamic Mindfulness and Mental Health First Aid. Staff designed the presentation to be highly interactive and to use language and concepts accessible to everyday community members. Staff first piloted Introduction to Mental Health in the earlier months of FY 17-18 with youth audiences during outreach activities with AYPAL, one of our community partner organizations, and "in-reach" activities at AHS' The Spot, another program of AHS where several youth activities are held. Staff also conducted the workshops for community members in central Alameda County at the San Leandro Main Public Library in May; this workshop was led in English, while Chinese and Vietnamese staff were available for interpretation as needed. Over time, Prevention program staff refined the presentation based on internal discussions as well as feedback from audience members. They finalized a standard version of the presentation and translated the written presentation from English into Korean, Chinese, and Vietnamese.

Lessons Learned:

Our accomplishments/successes taught us that we can continue to focus on and expand our Introduction to Mental Health workshops/presentations, regular support groups, and large community events. The more often we can count any workshops or trainings we do in the community as mental health consultation activities—i.e., provide the workshops to professionals and/or community leaders—the more it will benefit our consultation contract goal. Likewise, because our support groups and large-scale events have been very well-attended as outreach activities, we should continue to improve them so that more opportunities are created to find potential referrals for the Preventive Counseling program. The Prevention Program team has brainstormed a few ideas so far as to how to expand upon the current models of support groups and community events. One idea is to create more support groups, so that more new community members can enter the AHS SMH system and potentially access the Preventive Counseling service. Another idea is to make our few large-scale outreach events throughout the year more collaborative with other organizations or community resources, again as a way of reaching more untapped segments of our API communities who do not yet know about AHS SMH services.

Relevant Examples of Success/Impact:

Prevention outreach staff were trained this year by the Niroga Institute in Dynamic Mindfulness, an evidence-based, trauma-informed stress resilience program that applies mindfulness based practices to everyday life. Dynamic Mindfulness includes mindful movement, breathing techniques, and meditation. When integrated, these techniques are essential for stress management, self-care, and healing from personal and secondary trauma. Upon receiving the training, staff then began to incorporate dynamic mindfulness into various outreach and consultation activities, which allowed for an innovative method through which participants could engage in their own emotional well-being. Staff weaved short dynamic mindfulness activities into regular wellness support group meetings, our two large outreach events for the community, the Introduction to Mental Health workshops and other psycho-educational presentations, and while performing in-reach with other AHS department as our agency's primary mental health consultants. These activities had the benefits of allowing participants to learn how low-impact physical movement can be used to calm down, reduce anger/anxiety, and feel recharged. Participants also generally seem to enjoy how accessible, fun, and active dynamic mindfulness is.

Additional Information:

In this section please include the number of clients and/or contacts you estimate to serve in:
FY 18/19:
FY 19/20:

Any changes you intend to make to your program over the next three fiscal years?

- Meet or surpass our contractual goals to meet set numbers of outreach activities, mental health consultation activities, community contacts, preventive counseling cases, and mental health treatment referrals.
- Create new support groups, workshop series, and large-scale outreach events to reach more community members, especially around wellness topics that are relevant and timely to our communities. Some topic ideas are parent support and education, public safety, and technology and mental health in youth populations.
- Build relationships and collaborations with other API UELP-funded Prevention Programs in the county so that we can maximize our penetration rates of mental health outreach to all underserved API subpopulations.
- Continue to outreach and establish a presence in central Alameda County by building on relationships made at the San Leandro Moon Festival, San Leandro Public Library, and EHI Asian Outreach Committee.
- Strengthen our outreach activities in Southeast Asian community-based or faith-based organizations, such as those that are predominantly Vietnamese, Mien, and Cambodian, in order to build our Preventive Counseling and mental health treatment referral base in these communities.

Prevention Program
PEI Data Report FY 17/18

As required for each Prevention Program:

MHSA program Number: **PEI 6**

Program Name: **Center for Empowering Refugees and Immigrants (CERI) - Outreach, Education & Consultation for Asian Pacific Islander Community**

Program Description:

The mission of the Center for Empowering Refugees and Immigrants (CERI) is "to improve the social, psychological, and economic health of refugee families in which one or more individuals have been affected by war trauma, genocide, torture or another form of extreme trauma." Core services include: individual, family, and group counseling; case management, advocacy, and referrals; a range of wellness and enrichment activities; programs for children, teens, and Transition-Age Youth (TAY); and culturally-grounded community gatherings, projects, and events, on-site at CERI and in local community venues. CERI primarily serves Cambodian American clients—predominantly survivors of the Khmer Rouge genocide in Cambodia—and their families. Clients range in age from newborn to over eighty.

Number of **unduplicated** individuals served in the fiscal year (FY 17/18): 5,563

Number of individual family members (this number will be included in your total above): unknown

Demographics

Report disaggregate numbers served, number of potential responders engaged (for agencies conducting outreach), and number of referrals for treatment and other services for the following categories:

Age Group (Unduplicated)

Children/Youth (0---15)	703
Transition Age Youth (16---25)	1,012
Adult (26---59)	2,417
Older Adult (60+)	1,311
Declined to Answer	120

Race (Unduplicated)

American Indian or Alaska Native	22
Asian	4,424
Black or African American	182
Native Hawaiian or other Pacific Islander	
White	222
Other	55
More than one race	182
Declined to Answer	320

Ethnicity (Cultural Heritage)

Hispanic or Latino as follows:	
Caribbean	
Central American	
Mexican/Mexican---American/Chicano	
Puerto Rican	
South American	
Other	159
Declined to Answer	
Non---Hispanic or Non---Latino as follows:	
African	
Asian Indian/South Asian	2
Cambodian	4,142
Chinese	40
Eastern European	
European	
Filipino	1
Japanese	
Korean	6
Middle Eastern	49
Vietnamese	32
Other	146
More than one	
Declined to Answer	

Primary Languages

English	2,316
Spanish	
Chinese Dialect	
Japanese	
Filipino Dialect	
Vietnamese	14
Laotian	
Cambodian	3,182
Sign ASL	
Other Non---English	
Korean	
Russian	
Polish	
German	
Italian	
Mien	
Hmong	
Turkish	
Hebrew	
French	
Cantonese	
Mandarin	
Portuguese	
Armenian	
Arabic	
Samoan	
Thai	
Farsi	17
Other Sign	
Other Chinese Dialects	
Ilocano	

Sexual Orientation

Gay or Lesbian	15
Heterosexual or Straight	3,733
Bisexual	21
Questioning or unsure of sexual orientation	
Queer	
Another sexual orientation	7
Decline to Answer	1,693

Disability

Yes	2,421
Communication Domain:	
Difficulty Seeing	16
Difficulty hearing, or having speech understood	8
Other (specify)	8
Mental Domain	2,313
Physical/Mobility Domain	44
Chronic Health Condition	31
Other	1
No	2,540
Decline to Answer	602

Veteran Status

Yes	1
No	4,752
Decline to Answer	810

Gender

Assigned sex at birth:	
Male	1,399
Female	4,032
Decline to Answer	113
Current Gender Identity:	
Male	
Female	
Transgender	14
Gender queer	
Questioning or Unsure of Gender Identity	
Another Gender Identity	
Decline to Answer	

Total number of potential responders (outreach audience): 5,563

List type of setting(s) in which the potential responders were engaged and the type(s) of potential responders engaged in each setting:

Type of Setting(s) (ex: school, community center)	**Type(s) of Potential Responders** (ex: principals, teachers, parents, nurses, peers) Separate each type of responder with a comma.
Consultations One-to-one outreach (phone call or in-person face to face) Prevention Visit Psycho-education workshops Classes for community members Support Group Traditional healing workshop Training for professionals/leaders Radio/television Website/blogging Print Media	With family members, community leaders, community members, parents, professionals

Access and Linkage to Treatment <u>Strategy</u> (Required):

Number of individuals with SMI or SED referred to BHCS treatment system (includes county and CBO providers): unknown

List type(s) of treatment referred to:

During the hours of operation, CERI always has a Khmer-speaking staff member or volunteer available to provide services in Khmer and English. Trained interpreters from the community assist with confidential individual, family, and group therapy sessions, as needed. Interpreters also assist with community referrals as needed, including referrals to psychiatric, health care, legal, housing, and social services.
In addition to its on-site services, CERI also conducts about 30 to 40 percent of its services out in the community. CERI staff members regularly make home visits to meet with CERI families. CERI also maintains a heavy case management workload as, whenever a client is referred to a service, CERI usually follows up by helping clients set the appointment and accompanying them to the appointment.

This may entail going with a client to a medical appointment (with an interpreter, as needed), working with clients to help resolve SSI, Medi-cal, housing, immigration, and/or legal issues, and helping them navigate social services and legal systems. Recently, for example, one of the young men in CERI's youth program got arrested and the CERI case manager accompanied him to court and met with the probation officer. While he still has to serve his sentence, CERI's support will help him stay connected and ease his re-entry once released.
To support its ability to connect clients with needed services, CERI maintains strong partnerships with a range of community-based organizations (CBOs) and school-based programs. Ongoing community partners include: Asian Health Services, Bay Area Community Services (BACS), Bay Area Legal Aid, Banteay Srei, Homeless Action Center, and La Clinica Health Services.

Improving Timely Access to Services for Underserved Populations <u>Strategy</u> (Required):

Target population: CERI primarily serves Cambodian American clients—predominantly survivors of the Khmer Rouge genocide in Cambodia—and their families
Number of referrals to a **Prevention** program: unknown
Number of referrals to an **Early Intervention** program: unknown
Number of individuals followed through on referral & engaged in early intervention treatment services: unknown

Average time between referral and participation in treatment: unknown Standard Deviation: unknown

CERI interacts with other BHCS programs/projects in several ways. In terms of school-based programs, CERI works closely with counseling programs at various Oakland public schools to help CERI youth clients navigate issues that arise in the school setting and help these young clients to stay in school. CERI also supports BHCS's commitment to ensuring that underserved populations—particularly refugees and asylees—in Alameda County have access to mental health and wellness services. To this end, CERI is actively partnering and exploring projects with other community-based groups serving the local Southeast Asian population. These include: Asian Refugees United (ARU), which works with LGBTQ individuals in the Vietnamese refugee community; Banteay Srei, which serves as a resource for Southeast Asian young women at risk for sexual exploitation; Burma Refugee Family Network, which serves the local Burmese refugee community; Dig & Demand, an organization of "queer diasporic Vietnamese artists for justice"; and Lao Family Community Development, which serves the local Laotian refugee community.

Over the last year CERI has also integrated a new program, Wellness in Action, which provides wellness mini-grants to different local groups that want to do a mental health project for their community. This program component is expanding and CERI plans to hire one recent Wellness in Action grantee in the next fiscal year. Finally, CERI participates in BHCS's 10 x 10 campaign, which is designed to reduce disparities for individuals with mental health challenges, by organizing rides and providing transportation stipends for clients to attend public health walks and fairs and other related community events.

And/Or:

Number of referrals to **BHCS treatment system (beyond early onset):** unknown
Number of individuals followed through on referral & engaged in treatment: unknown
Average time between referral and participation in treatment: unknown Standard Deviation: unknown

As required for each Prevention <u>Program</u>:

Implementation Challenges:

As CERI expanded its services and wellness activities, it encountered several challenges. First, in order to provide expanded services to meet client demand and provide new wellness programs, CERI found it needed to increase its staffing levels. It addressed this challenge by expanding its intern program to be able to provide expanded counseling hours and wellness programming.

Secondly, the increase in clinical services and wellness programming resulted in scheduling issues and prompted ongoing discussions of how best to use the CERI space and accommodate expansion. CERI addressed this challenge by opening its center seven days a week to provide a greater number of activities. Other community groups (e.g., Banteay Srei, Asian Refugees United) also sometimes use CERI's center for meetings.
This expansion has also caused some challenges for CERI's primary client community, the Cambodian refugee community, which has come to view CERI as a safe and welcoming gathering space—an important part of healing for clients who saw their families and communities destroyed during the Khmer Rouge genocide. It is understandable, therefore, that there have been some minor growing pains as the center opens up to accept interns, staff, consultants, and, on occasion, participants from other Southeast Asian groups and other refugee/asylee communities, including individuals with different religious and cultural practices. CERI continues to work on this cultural adjustment by holding group discussions about the expansion plans and about cultural differences and stereotypes. It also continues to encourage its Cambodian refugee clients to embrace their role as community leaders, welcoming newcomers and sharing their wisdom, experience, and culture with—while also learning from—individuals from a varieties of backgrounds.

Success:

Over the past year CERI has focused on strengthening and deepening its program model to better support clients. Below are descriptions of specific areas in which CERI had notable successes and accomplishments:

Multigenerational Approach: CERI has had a longstanding commitment to employing a multigenerational approach to mental health and wellness. This year marked the third consecutive year in which CERI was able to serve both adult and youth clients through its MHSA contract.

Increased Wellness Programming: CERI added two new programs to its wellness offerings over the last year. In the fall, CERI contracted with "ARTogether" a local nonprofit that does expressive arts therapy with refugees, led by refugees. During the contract period, ARTogether worked with CERI youth to help them use art as a means to explore issues of identity and self-expression.

Increased Community Outreach: Another important development this year was that CERI increased its community outreach. CERI staff gave presentations to professionals at local mental health agencies, hospitals, universities, and community groups that serve refugees and asylees, to inform them about the CERI model and offer recommendations for delivering culturally-sensitive trauma-informed mental health services to refugee families. CERI also welcomed site visits from other agencies who wished to observe its programs.

Reconnecting with Cambodian Roots:

As CERI's older adult clients heal over time, they are beginning to reclaim their relationship to their home country, something which has been too painful in the past. Last year, a number of CERI's elders provided testimonies for the war tribunal in Cambodia, in partnership with the Center for Justice and Accountability (CJA).

Lessons Learned:

The main lesson that CERI has learned is the importance of maintaining an ongoing and open dialogue with clients as programmatic and organizational changes are introduced. CERI has found that trust and communication are the keys to creating a therapeutic environment in which all clients can feel safe and respected and, at the same time, explore, heal, change, and grow. To assist with this mission, over the last year CERI has actively partnered with more agencies to help introduce CERI clients to new healing modalities (e.g., Drama Therapy, Expressive Arts Therapy) and to create projects and forums for engaging clients of different generations and perspectives in an ongoing dialogue about identity, community, and cultural values.

CERI has also found that employing interns is a cost effective way for it to expand its clinical and wellness activities during this time of growth. As it prepares to continue to explore new partnerships and opportunities for deepening its services, CERI will also engage in cross-training and dialogue with project partners, as well as ongoing training and professional development for new staff and interns (particularly around trauma issues), to ensure that the organization stays true to its founding mission and unique community-based trauma-informed program model as it grows.

Additional Information:

In this section please include the number of clients and/or contacts you estimate to serve in:
FY 18/19:
FY 19/20:

Any changes you intend to make to your program over the next three fiscal years:

CERI has three interrelated goals for the upcoming year.
1) Build its capacity to serve the current and emerging needs of its multigenerational client population through

expanded services and wellness programs; this includes building out its new Drama Therapy and Expressive Arts programs and introducing stigma reduction projects with an LGBTQ focus, to engage the CERI community in a dialogue about biases and to promote acceptance and inclusion of LGBTQ individuals—particularly youth—within the Southeast Asian community.

2) Continue to expand the number of individuals impacted by the CERI model, through expanded on-site services and programs for CERI clients and through strategic partnerships with other local organizations.

3) Diversify and expand funding sources to sustain and grow CERI's program over the next five years.

Prevention Program
PEI Data Report FY 17/18

As required for each Prevention Program:

MHSA program Number: **PEI 6**

Program Name: **Community Health for Asian Americans (CHAA) - Outreach, Education & Consultation for Asian Pacific Islander Community**

Program Description:

Community Health for Asian American's serves to provide community-driven behavioral health services, family support, youth development and advocacy for the historically underserved API communities in the Bay Area. Since 2010, through our Asian Pacific Islander Connections (APIC) program, CHAA has offered a continuum of community-driven services in behavioral health care, including Prevention & Early Intervention, with an emphasis on youth development and family support.

Number of **unduplicated** individuals served in the fiscal year (FY 17/18): 2,709
Number of individual family members (this number will be included in your total above): unknown

Demographics

Report disaggregate numbers served, number of potential responders engaged (for agencies conducting outreach), and number of referrals for treatment and other services for the following categories:

Age Group (Unduplicated)

Children/Youth (0---15)	311
Transition Age Youth (16---25)	438
Adult (26---59)	1,639
Older Adult (60+)	270
Declined to Answer	51

Race (Unduplicated)

American Indian or Alaska Native	30
Asian	2,551
Black or African American	17
Native Hawaiian or other Pacific Islander	
White	34
Other	67
More than one race	
Declined to Answer	10

Ethnicity (Cultural Heritage)

Hispanic or Latino as follows:	
Caribbean	
Central American	
Mexican/Mexican---American/Chicano	
Puerto Rican	
South American	
Other	5
Declined to Answer	
Non---Hispanic or Non---Latino as follows:	
African	
Asian Indian/South Asian	2
Cambodian	
Chinese	10
Eastern European	
European	
Filipino	5
Japanese	
Korean	
Middle Eastern	
Vietnamese	
Other	2,536
More than one ethnicity	
Declined to Answer	

Primary Languages

English	211
Spanish	
Chinese Dialect	
Japanese	
Filipino Dialect	
Vietnamese	
Laotian	
Cambodian	
Sign ASL	
Other Non---English	2,126
Korean	
Russian	
Polish	
German	
Italian	
Mien	
Hmong	
Turkish	
Hebrew	
French	
Cantonese	1
Mandarin	
Portuguese	
Armenian	
Arabic	
Samoan	
Thai	378
Farsi	
Other Sign	
Other Chinese Dialects	
Ilocano	

Sexual Orientation

Gay or Lesbian	
Heterosexual or Straight	2,370
Bisexual	
Questioning or unsure of sexual orientation	
Queer	
Another sexual orientation	
Decline to Answer	339

Disability

Yes	26
Communication Domain:	
Difficulty Seeing	
Difficulty hearing, or having speech understood	4
Other (specify)	
Mental Domain	3
Physical/Mobility Domain	5
Chronic Health Condition	12
Other	2
No	1,658
Decline to Answer	1,025

Veteran Status

Yes	2
No	1,829
Decline to Answer	878

Gender

Assigned sex at birth:	
Male	1,039
Female	1,670
Decline to Answer	
Current Gender Identity:	
Male	
Female	
Transgender	
Genderqueer	
Questioning or Unsure of Gender Identity	
Another Gender Identity	
Decline to Answer	

Total number of potential responders (outreach audience): 2,709

List type of setting(s) in which the potential responders were engaged and the type(s) of potential responders engaged in each setting:

Type of Setting(s) (ex: school, community center)	**Type(s) of Potential Responders** (ex: principals, teachers, parents, nurses, peers) Separate each type of responder with a comma.
Consultations One-to-one outreach (phone call or in-person face to face) Prevention Visit Psycho-education workshops Classes for community members Support Group Traditional healing workshop Training for professionals/leaders Website/blogging	With family members, community leaders, community members, parents, professionals

Access and Linkage to Treatment <u>Strategy</u> (Required):

Number of individuals with SMI or SED referred to BHCS treatment system (includes county and CBO providers): unknown

List type(s) of treatment referred to: Unknown

- Listening to the community and partners to identify a way that our program could be helpful to provide culturally-linguistically appropriate services (e.g. conducting more large-scale needs assessments)
- Become familiar with targeted communities through greater engagement efforts and building trust to serve API populations better
- Building a foundation of knowledge to prioritize community needs
- Our community wellness advocates and clinicians learned that having a clear understanding of the needs of our
- API communities and clients helps empower them to be better served
- Sustainability of services is a big concern for some API clients concerned about the funding cuts that have impacted APIC's Tongan and Nepalese Community Wellness Advocates.
- There is dire need regarding our experience working with these priority population in the program.
- There is a positive relationship between individuals and families, how they navigate resources and how that influenced and improved their overall well-being and continued wellness of the API communities.

Improving Timely Access to Services for Underserved Populations Strategy (Required):

Target population: Our targeted population is Burmese, Bhutanese, Nepalese, Mongolian, Thai, Tibetan and Pacific Islander (Tongan). We have abundant experience in working with refugee/ asylee and immigrant populations from these same ethnic communities APIC served API populations through our core values that include: (1) Promoting health equity, (2) Cultural Knowledge - Awareness- Sensitivity- Competence, (3) Creating an inclusive community.
Number of referrals to a **Prevention** program: unknown
Number of referrals to an **Early Intervention** program: unknown
Number of individuals followed through on referral & engaged in early intervention treatment services: unknown
Average time between referral and participation in treatment: unknown Standard Deviation: unknown

And/Or:

Number of referrals to **BHCS treatment system (beyond early onset):** unknown
Number of individuals followed through on referral & engaged in treatment: unknown
Average time between referral and participation in treatment: unknown Standard Deviation: unknown

As required for each Prevention Program:

Implementation Challenges:

APIC has provided prevention and early intervention services in emerging Asian immigrants and refugee communities. This challenge is associated with lack of access to resources and very few bilingual staff and people within these communities who can provide interpretation, case management, consultations and resources and referrals. Our community wellness advocates and clinicians in mental and behavioral health care engage in discussions throughout Alameda County about these challenging factors we face in API communities. These engaged discussions entail what needs to be done, what can be done, and how the APIC program has effectively & innovatively integrated services, community-driven approaches and cultural relevance services with the goal that API and refugee communities have access to comprehensive assessments and coordination for mental health, physical health, and other services.

APIC staff have made a positive impact on the well-being of our growing number of clients and communities that we support. However, when working for underserved communities, new challenges and a shift in immigrant communities needs change; this shift of issues and needs by API and refugee communities in Alameda County include, (1) Trauma related to Domestic Violence and other forms of violence, (2) Homelessness, (3) Social isolation due to different levels of acculturation to US culture (4) Depression, (5) Anxiety, (6) Generation gaps (7) Issues relating to social and emotional development of children unable to experience, express, and establish positive emotions (8) Gender roles confusion (with traditional family function) that can lead to self-esteem issues (9) Refugee Resettlement (10) Traumatic experiences both from the past and current violent situations they face (11) Social stigma around mental health issues (12)Financial issues (13) Resources due to language limitation or barriers. (14) 59% of children in Oakland underserved.

Success:

It has been almost a decade since the APIC program at CHAA has helped tens of thousands of API communities. Throughout the last 8 years of APIC's operational function, there has been overall shift in how we provide care and support for our clients. In the launch APIC program 8 years ago, we took a reactive approach to mental health support and now we take a more proactive method that creates healthier communities thought Alameda County. The proactive approach includes building, sustaining and creating collaborative public and mental health system, creating community partnerships and health promotion events, and providing prevention and early Intervention services. At APIC, our clinical consultants, community API advocates are closing the gap in the health system infrastructure and creating more effective ways to deliver culturally competent mental health services.

In recognition of APIC 8-year anniversary, we want to highlight the importance to address mental health disparities. Reducing health inequities is important because health and wellbeing is a fundamental human rights and its realization will eliminate inequalities that result from differences in health and mental health status (such as mental or emotional health challenges or disabilities) in the opportunity to enjoy life and pursue one's life plans.

Lessons Learned:

This significant shift in demand means that APIC needs to ensure that there is financial and organizational sustainability to better support the growing API client population. In addition to the shift, the needs and growing number of early intervention and prevention clients currently fund cuts to our Tongan & Bhutanese/Nepalese Wellness Advocate and has led to fiscal and funding instability to our API populations. Currently over 50% of Tongan clients and community members in Alameda County are experiencing, suicidal thoughts and severe depression as they try to adapt to American life. In addition, the effect of cultural influences on health and illness, mistrust western psychological approaches and clinical strategies to improve mental health care for immigrants and refugees. Specific challenges in emerging Asian immigrants and refugee communities for mental health include communication difficulties because of language and cultural differences; the effect of cultural shaping of symptoms and verbal expressions, ignoring feelings and illnesses, behavior on diagnosis, coping, treatment; differences in family structure and process affecting adaptation, acculturation and intergenerational conflict; and aspects of acceptance by the receiving society that affect employment, social status and integration and discrimination. Often times, Individuals and families do not recognize problems, and lack understanding about mental health care which causes delays, seeking services or have been denied services.

Relevant Examples of Success/Impact:

APIC ensures that wellness advocates have the confidence and skills required to assert and articulate their respective API communities' needs, assets, and concerns successfully. The goal of our workforce development training is to produce effective leaders that are well-versed and culturally competent. Our trainings are also aimed at ensuring that our advocates have an in-depth psychological understanding of cultural, race, ethnicity, most-up-to date cultural adaptations of psychological measures, community based participatory research and cross-national, biological and genetic approaches to mental health support. APIC provides training on organizational and membership development, as well as on such critical integration issues as access to social services, promotion of civic engagement, career development, knowledge of refugee/immigrant rights and responsibilities and access to resources.

Additional Information:

In this section please include the number of clients and/or contacts you estimate to serve in:
FY 18/19:
FY 19/20:

Any changes you intend to make to your program over the next three fiscal years:

- Improve access to resources and quality of care; Improve data system and quality assurance
- Publish bi-lingual mental health material and resources
- Expand our reach in providing psycho- education, traditional belief and culture, and education
- Mindfulness based stress reductions
- Conduct community outreach campaigns on suicide prevention awareness and multi- cultural awareness.
- Ethnic-based social media campaign
- Staff professional development
- Integrate more culturally welcoming practices such as rituals, sharing food, socialization, storytelling on mental health and well-being services.
- Make important efforts towards sustainability, mental health systems.
- Make key efforts to protect and prioritize the well-being, interests, and rights of communities.
- Eliminate stigma on mental health services, and misunderstanding of mistrust on mental health services.

Prevention Program
PEI Data Report FY 17/18

As required for each Prevention Program:

MHSA program Number: **PEI 7**

Program Name: **Hume Center's South Asian Community Health Promotion Services - Outreach, Education & Consultation for South Asian/Afghan Community**

Program Description:

The SACHPS program offers community programs and services that are uniquely and best suited for participants from India, Pakistan, Bangladesh, Sri Lanka, Afghanistan and Nepal whether that is an individual, family, community, or organization. In developing community programs and services, we take into account the social, psychological, economic and cultural factors of the people who we are serving. Our programs are aimed at reducing risks and stressors, enhancing skills and developing and/or strengthening supportive processes and structures. Our Prevention Services are designed to solve stressful life problems before they can result in dysfunction and prolonged suffering. These objectives are achieved through outreach and education, community mental health consultations and early intervention services. These services enhance the populations to increase their chances for health and success in their lives and to reduce pressure on the overburdened social safety net.

Number of **unduplicated** individuals served in the fiscal year (FY 17/18): 2,425
Number of individual family members (this number will be included in your total above): unknown

Demographics

Report disaggregate numbers served, number of potential responders engaged (for agencies conducting outreach), and number of referrals for treatment and other services for the following categories:

Age Group (Unduplicated)

Children/Youth (0---15)	575
Transition Age Youth (16---25)	204
Adult (26---59)	1,293
Older Adult (60+)	353
Declined to Answer	0

Race (Unduplicated)

American Indian or Alaska Native	5
Asian	1,586
Black or African American	27
Native Hawaiian or other Pacific Islander	
White	131
Other	143
More than one race	
Declined to Answer	533

Ethnicity (Cultural Heritage)

Hispanic or Latino as follows:	
Caribbean	
Central American	
Mexican/Mexican---American/Chicano	
Puerto Rican	
South American	
Other	84
Declined to Answer	
Non---Hispanic or Non---Latino as follows:	
African	
Asian Indian/South Asian	934
Cambodian	
Chinese	3
Eastern European	
European	
Filipino	69
Japanese	
Korean	
Middle Eastern	
Vietnamese	5
Other	505
More than one ethnicity	
Declined to Answer	

Primary Languages

English	1,720
Spanish	
Chinese Dialect	
Japanese	
Filipino Dialect	
Vietnamese	
Laotian	
Cambodian	
Sign ASL	
Other Non---English	571
Korean	
Russian	
Polish	
German	
Italian	
Mien	
Hmong	
Turkish	
Hebrew	
French	
Cantonese	
Mandarin	
Portuguese	
Armenian	
Arabic	4
Samoan	
Thai	
Farsi	130
Other Sign	
Other Chinese Dialects	
Ilocano	

Sexual Orientation

Gay or Lesbian	
Heterosexual or Straight	
Bisexual	
Questioning or unsure of sexual orientation	
Queer	
Another sexual orientation	
Decline to Answer	

Disability

Yes	74
Communication Domain:	
Difficulty Seeing	2
Difficulty hearing, or having speech understood	
Other (specify)	
Mental Domain	8
Physical/Mobility Domain	63
Chronic Health Condition	1
Other	1,222
No	1,129
Decline to Answer	

Veteran Status

Yes	2
No	1,124
Decline to Answer	2,415

Gender

Assigned sex at birth:	
Male	857
Female	1,568
Decline to Answer	
Current Gender Identity:	
Male	
Female	
Transgender	
Genderqueer	
Questioning or Unsure of Gender Identity	
Another Gender Identity	
Decline to Answer	

Total number of potential responders (outreach audience): 2,425

List type of setting(s) in which the potential responders were engaged and the type(s) of potential responders engaged in each setting:

Type of Setting(s) (ex: school, community center)	**Type(s) of Potential Responders** (ex: principals, teachers, parents, nurses, peers) Separate each type of responder with a comma.
Consultations One-to-one outreach (phone call or in-person face to face) Prevention Visit Psycho-education workshops Classes for community members Support Group Traditional healing workshop Training for professionals/leaders Print Media Radio/television	With family members, community leaders, community members, parents, professionals

Access and Linkage to Treatment <u>Strategy</u> (Required):

Number of individuals with SMI or SED referred to BHCS treatment system (includes county and CBO providers): unknown

List type(s) of treatment referred to:

- We developed fliers with no psychological jargon. The South Asian program team was trained to address the community members they serve using similar terminology on the flyers.
- Participants have been referred to long term prevention counseling services, outpatient medi-cal services, support groups, and wellness centers.
- Clinicians have helped the participants make appointments and followed up with participants as well as the referral agencies to ensure the participants are connected.
- Clinicians have collaborated and shared information with providers when necessary for the health and benefit of their participants and with their participant's consent.
- Having a staff with diverse backgrounds, speaking their language helps in creating trust and building rapport and supports successful linkages to other programs.

Improving Timely Access to Services for Underserved Populations <u>Strategy</u> (Required):

Target population: The SACHPS program offers community programs and services that are uniquely and best suited for participants from India, Pakistan, Bangladesh, Sri Lanka, Afghanistan and Nepal whether that is an individual, family, community, or organization.

Number of referrals to a **Prevention** program: unknown
Number of referrals to an **Early Intervention** program: unknown
Number of individuals followed through on referral & engaged in early intervention treatment services: unknown

Average time between referral and participation in treatment: unknown Standard Deviation: unknown

- We were able to have guest speakers come and present at our staff meetings to share the work they do and how we can collaborate our efforts.
- We visited the Fremont Resource Center, SAVE, and Afghan wellness center as well as gurdwaras, temples, mosques and domestic violence shelters to learn about the work they do and to give and receive support from them.
- We attended, tabled, and presented at conferences that were organized by other agencies (Tri-city Health Fair, We move for Health, South Asian Mental Health Consortium, California Psychological Association, domestic violence shelters, India community center, high schools, and local libraries) to co-sponsor and host workshops in the community.

And/Or:

Number of referrals to **BHCS treatment system (beyond early onset):** unknown
Number of individuals followed through on referral & engaged in treatment: unknown
Average time between referral and participation in treatment: unknown Standard Deviation: unknown

As required for each Prevention Program:

Implementation Challenges:

- Commitment to long term support groups continued to be a challenge due to the stigma for mental health that is prevalent in the community, identification with a problem and commitment to meeting every week were a challenge. Consultants were able to mitigate this challenge by recruiting several months in advance and holding emotional wellness camps for children during the summer months when parents are more likely to permit their children to participate in activities that are not purely academic. Culturally academics take precedence in South Asian communities so our team creatively promoted the groups as summer camps and were able to strategize ways that parents would be interested in sending their children.
- Through our understanding of this community we learned that collaborating primarily with agencies and providers of South Asian descent serving South Asians can sometimes be counterproductive so this year we made a conscious effort to do outreach to Hospitals, and on the Radio to that reach a larger audience in order to increase visibility within the community,
- Some religious/cultural groups were more difficult to engage in services. We tried to be persistent in our attempts to engage with them which resulted in establishing contact with a women led mosque in Berkeley and the Baha'i Iranian community.

Success:

- We continued providing consultation to agencies and organizations who also serve the South Asian population. Through consultation, staff can better help their clients and address early mental health needs. Consultation helps strengthen the process by understanding the client's needs. High levels of satisfaction were reported by the staff of agencies where we provided services (ICC, EBAC, St. Bedes).
- Provided consultation to the administrators of a middle school in Union City (Cesar Chavez) that approached us to understand the behavioral challenges presented by the students that they worked with and enabling them to develop ways to respond that helped them manage those behaviors effectively.
- Conducted art based and mindfulness workshops for seniors at the Fremont Senior Center.
- Our repeated participation at outreach events has been instrumental in increasing awareness and building trust with the community members who feel comfortable approaching us to consult with us and refer friends and family. We participated in outreach at Sevathon- a marathon organized in the spirit of service, health and wellness, continued to draw large crowds to our table. It was an event attended by over 5,000 people and over 110 nonprofit organizations from the South Asian community.
- Our consultants were mentors to high school students who conducted research on socially relevant topics like decreasing stigma of mental health in the South Asian community (e.g., A high school student worked with a consultant from the program to reach out to faith leaders and consumers in the community to spread awareness about mental health stigma and increasing awareness of services).
- We collaborated with other organizations like Afghan Coalition, Narika, Maitri, and SAVE and offered workshops to the community. Some of the workshops offered were: attaining work life balance, mindful parenting, media use in teens, teen sleep, cultural diversity, transitions in life, acculturation and immigration , enhancing emotional wellness and increasing coping skills and conducted info sessions on decreasing stigma of mental health, Understanding Trauma and Self Care.
- We conducted a series of well attended workshops at St. Bedes with teachers and parents on topics identified by them to help them better connect their students and children.
- There was a higher number of self-referrals particularly from males and engagement of families. This reflects a changing trend as our services are becoming more well-known and accepted by the community.
- We are serving and are accessible to communities with limited resources because the people we provide services to do not have insurance and need additional help accessing services such as housing, food stamps, transportation, or income support and through this program we are able to link them to agencies that assist with those needs.

Lessons Learned:

- We learned that we must continue to use creative and innovative ways to reach out to this community.
- We learned that when a community is resisting or avoiding our services, it's important to be flexible and change the way the service is delivered for maximum impact.
- We learned that we need to be even more visible in our community and use more social media and technological tools.
- We learned that we do have to change our model depending on what a participant is ready for.

Relevant Examples of Success/Impact:

Historically this program has faced challenges in recruiting participant's to attend groups due to the stigma of sharing personal information with people who are not in their immediate family. This year an emotional wellness summer camp was offered for teens and younger youth. Recruiting began six months in advance at schools, community centers and health fairs. Parents appreciated the availability of the services and our team worked on a curriculum that enhanced emotional wellness and promoted sharing and communication skills. The camps have been a success and are currently still running. They have also been a referral source for ongoing one-on-one prevention counseling services as some parents identified that their children would benefit from the continuous support.

Additional Information:

In this section please include the number of clients and/or contacts you estimate to serve in:

FY 18/19:
FY 19/20:

Any changes you intend to make to your program over the next three fiscal years:

- Our major goal for this upcoming fiscal year is to expand services to North County specifically to serve the underserved Nepalese and Bhutanese population. Since we have a team that has a well-trained and seasoned group of clinicians and an effective delivery system, we are going to focus the services we have developed and hope to reach out to more individuals via outreach and education events as well as educational workshops and groups.
- We will expand the scope of our outreach activities to reach different sub groups within the community by making connections with places of worships like mosques and temples and community centers that are frequented by members who may not attend mainstream centers of worship and social support.
- We will offer more psycho-educational workshops for skill building in topics like sleep hygiene, stress reduction, self-care, communication skills, and mindfulness for e.g.
- We will enhance our use of social media in outreach and education to reach out to more youth.
- We will offer more mental health related trainings for professionals who work with the South Asian community.
- We will offer a more varied range of workshops on health and wellness topics for our community.
- Expand services at our current off site locations (schools and community centers) by building on the connections we have already made and offering workshops and groups to reach more participants within those systems.

Prevention Program
PEI Data Report FY 17/18

As required for each Prevention Program:

MHSA program Number: **PEI 7**

Program Name: **The Afghan Wellness Center** - **Outreach, Education & Consultation for Afghan Community**

Program Description:

The Afghan Wellness Center (AWC) is a project of The Afghan Coalition (AC), a non-profit, community based organization located in Fremont. AC consist of a bilingual/bi-cultural staff and volunteers who work to empower underserved Afghan families, women and youth living in Alameda County with the support needed to live healthy and productive lives. The AWC provides early intervention and prevention for the mental health issues experienced by the Afghan community. Forty years of war in Afghanistan destroyed the infrastructure, culture and beliefs of the Afghan Community. A 2009 survey conducted by a Rate Specialist at Cal State East Bay in partnership with the Afghan Coalition found 45% of Afghans suffer from PTSD and women are almost twice as likely as men to suffer from it. 87% of Afghan women have experienced domestic violence. In addition, 61% of those who were classified as having PTSD on the survey have been diagnosed with depression by a medical or mental health professional. The AWC works with individuals that are isolated or trauma-exposed, immigrants, families under stress or grieving, at-risk children and youth by providing 1) Community Cultural/Educational/Outreach Activities, 2) Wellness and Mental Health Workshops, 3) Conducting Support Groups, 4) Providing advocacy and supportive social service assistance, 5) Providing Prevention and Early Intervention services in Dari, Pashto and English. In the course of our work, AWC may also identify individuals, at-risk of early onset of a serious mental health issue and provide needed referral services.

Number of **unduplicated** individuals served in the fiscal year (FY 17/18): 2,129

Number of individual family members (this number will be included in your total above): unknown

Demographics

Report disaggregate numbers served, number of potential responders engaged (for agencies conducting outreach), and number of referrals for treatment and other services for the following categories:

Age Group (Unduplicated)

Children/Youth (0---15)	11
Transition Age Youth (16---25)	41
Adult (26---59)	1,005
Older Adult (60+)	10,033
Declined to Answer	39

Race (Unduplicated)

American Indian or Alaska Native	
Asian	1,592
Black or African American	101
Native Hawaiian or other Pacific Islander	
White	54
Other	
More than one race	
Declined to Answer	324

Ethnicity (Cultural Heritage)

Hispanic or Latino as follows:	
Caribbean	
Central American	
Mexican/Mexican---American/Chicano	
Puerto Rican	
South American	
Other	
Declined to Answer	
Non---Hispanic or Non---Latino as follows:	
African	
Asian Indian/South Asian	
Cambodian	
Chinese	
Eastern European	
European	
Filipino	
Japanese	
Korean	
Middle Eastern	
Vietnamese	
Other Afghan (1,535) Other Asian (57)	1,592
More than one ethnicity	
Declined to Answer	

Primary Languages

English	804
Spanish	
Chinese Dialect	
Japanese	
Filipino Dialect	
Vietnamese	
Laotian	
Cambodian	
Sign ASL	
Other Non---English	1,309
Korean	
Russian	
Polish	
German	
Italian	
Mien	
Hmong	
Turkish	
Hebrew	
French	
Cantonese	
Mandarin	
Portuguese	
Armenian	
Arabic	11
Samoan	
Thai	
Farsi	5
Other Sign	
Other Chinese Dialects	
Ilocano	

Sexual Orientation

Gay or Lesbian	
Heterosexual or Straight	2,018
Bisexual	2
Questioning or unsure of sexual orientation	
Queer	
Another sexual orientation	
Decline to Answer	109

Disability

Yes	339
Communication Domain:	
Difficulty Seeing	
Difficulty hearing, or having speech understood	
Other (specify)	
Mental Domain	45
Physical/Mobility Domain	231
Chronic Health Condition	2
Other	61
No	976
Decline to Answer	814

Veteran Status

Yes	0
No	1,486
Decline to Answer	2,129

Gender

Assigned sex at birth:	
Male	1,131
Female	996
Decline to Answer	1
Current Gender Identity:	
Male	
Female	
Transgender	1
Genderqueer	
Questioning or Unsure of Gender Identity	
Another Gender Identity	
Decline to Answer	

Total number of potential responders (outreach audience): 2,129

List type of setting(s) in which the potential responders were engaged and the type(s) of potential responders engaged in each setting:

Type of Setting(s) (ex: school, community center)	**Type(s) of Potential Responders** (ex: principals, teachers, parents, nurses, peers) Separate each type of responder with a comma.
Consultations One-to-one outreach (phone call or in-person face to face) Prevention Visit Psycho-education workshops Classes for community members Support Group Traditional healing workshop Training for professionals/leaders Radio/television Website/blogging	With family members, community leaders, community members, parents, professionals

Access and Linkage to Treatment Strategy (Required):

Number of individuals with SMI or SED referred to BHCS treatment system (includes county and CBO providers): unknown

List type(s) of treatment referred to:

The Afghan Coalition works closely with over 30 community organizations and agencies including the City of Fremont and Alameda County Health and Human Services.

AWC has encouraged access to our programs through community outreach events, by working closely with other agencies such as FERC and through weekly television programs and social media to name a few. For example, FERC and AWC held an eight (8) week support group called, Family Wrap. The goals of Wrap were to help clients learn coping skills to help them feel better when they are not doing well, develop a plan of action towards achieving personal wellness and learn tools and strategies to help with their daily life. We also refer clients from Afghan Coalition as necessary.

Improving Timely Access to Services for Underserved Populations Strategy (Required):

Target population: The AWC provides early intervention and prevention for the mental health issues experienced by the Afghan community.
Number of referrals to a **Prevention** program: unknown
Number of referrals to an **Early Intervention** program: unknown
Number of individuals followed through on referral & engaged in early intervention treatment services: unknown
Average time between referral and participation in treatment: unknown Standard Deviation: unknown

One of the ways we interact with the various BHCS programs is working closely with FERC agency and referring our clients when necessary. We also did a six (6) week support group for the new arrivals. One of those workshops presented was “Wellness Recovery Action Plan for Families.”

In the future, we hope to invite the partner programs to participate at our consortium meeting so we can work closely and train each other on cross cultural issues.

And/Or:

Number of referrals to **BHCS treatment system (beyond early onset):** unknown
Number of individuals followed through on referral & engaged in treatment: unknown
Average time between referral and participation in treatment: unknown Standard Deviation: unknown

As required for each Prevention Program:

Implementation Challenges:

One of the challenges that we have faced is finding qualified mental health professionals who understand the mental health issues that are unique to the Afghan community. We are currently in the process of seeking out qualified candidates in a variety of positions. We will also provide opportunities for new and current staff to attend seminars, classes and/or education workshops about mental health issues.

Another challenge we face is targeting members of the community who do not have any means of transportation and/or are not aware of the services that we provide. One of the ways that we have tried to combat this is by providing a weekly Afghan television program that discusses mental health and cultural issues. Our vision for the next year is to do further outreach to capture new clients through new youth programs, a weekly men's group and continue to expand our women's groups. We will also provide home visits to reach and engage new clients. Our ultimate goal is to encourage clients to become more knowledgeable, confident and self-sufficient navigating the health care system and taking ownership of their own well-being including mental health care.

Additionally, we had the challenge of several key staff members resigning all at the same time. We were able to mitigate this challenge by mobilizing the remaining staff and smoothly transitioning the office so that our client's needs continued to be met. Within days of the transition, the remaining staff completed HIPAA training and attended MAA training provided by BHCS.

Success:

The AWC and the staff have been successful in building awareness regarding mental health and further reducing the stigma that exist in our community by educating the clients about mental health issues and stressing the importance of seeking care.

In May 2018, we added two important Afghan Coalition existing support groups to AWC which made a significant impact on the mental health programs. We are providing quality services to our clients that not only addresses their mental health needs but it is done in a culturally sensitive manner. This has changed our client's perspective towards mental health.

Our women's support groups continue to grow and be one of our most popular programs. It reaches many women facing isolation, cultural adjustment and other every day stressors. Because the Afghan women plays such a central nurturing role in the Afghan family, the support groups help bring awareness to our community about the importance of mental health services and the potential rewards of practicing self-care.
The weekly support group has covered a variety of topics geared towards improving the lives of the women we serve. Topics discussed include issues such as Communication, Self-Care, Domestic Violence, Art Therapy and Yoga. Recently, we held a self-defense class which taught the importance of controlled emotions, aimed to reduce anxiety in public areas and taught the participants basic self-defense. Many women in the Afghan community walk to various locations and feel unsafe. Some have experienced discrimination in public. By participating in this workshop the women gained confidence and learned where to go and what to do if they feel unsafe in public. A client, who attends one of the weekly support groups and is a widow struggling with grief, said, "I used to feel so down but now I am so happy. This place is my hospital". Her learned self-care and coping skills are empowering her and giving her confidence to deal with her new life.

Additional support groups included a Domestic Violence workshop and support group. This is an eight week program for survivors of domestic violence that includes a graduation and certificate of completion for each member. We run three domestic violence workshops per year. Last year, we started an alumni support group so that the graduates can become mentors to the women and families in their community.

Lessons Learned:

During the seven years we have worked in the community, we learned our community members are in desperate need of outreach and education to understand their physical and mental health.

From our challenges, we learned the importance of reaching the underserved community with educational campaigns to change the negative attitudes and misconceptions that come from seeking mental health. Replacing misconceptions surrounding mental health with facts can help the community better understand the need for mental health services.

We also learned that in a support group environment women tend to open up and share more when they are doing an activity such as jewelry making, sewing or preparing food together. It gives the women a safe place to let their guard down, open up about their lives and promote personal and social wellness.

Relevant Examples of Success/Impact:

Another success was an outreach for men. This event was organized by The Danish Cultural Association for Uber drivers, and other men, who were feeling overwhelmed from the demands of their jobs. The program was successful in reducing stress and isolation by offering these men an opportunity to participate in an activity they enjoy with people from their own community. In April, the Danish Cultural Association organized a Nowrooz event celebrating the Afghan New Year at Quarry Lake Park. Over 200 people attended including many families and children. Activities included a BBQ, games and candy for the children and sports activities for everyone. Danish Cultural Association hosted two other programs. One was a health through sports program in May where 22 young men participated in volleyball and soccer. A Parent and Family Workshop was also held to discuss how to bridge the gap between the new and old generations. Pictures below of the Danish Cultural events.

Additional Information:

In this section please include the number of clients and/or contacts you estimate to serve in:

FY 18/19:

FY 19/20:

Any changes you intend to make to your program over the next three fiscal years:

One of our goals for the upcoming year is to further expand our outreach, awareness and education for our community members. And to educate other agencies who assist the Afghan community to bring culturally sensitive services to our establishment. We will develop several promotional and educational materials to be distributed to schools, health care providers and other agencies who interact with our community. Staff will be on-site to provide preventive counseling to men, women and youth. In addition to our women's support group we will add a men's and youth support group in a safe, inviting environment so they can start opening up and talking about their mental health issues and learn coping skills. Additionally, The Health Leadership Consortium quarterly meetings will continue to be an effective mechanism for collaboration with community leaders and public and community-based organization in the design and implementation of culturally responsive programs.

Prevention Program
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As required for each Prevention Program:

MHSA program Number: **PEI 8**

Program Name: **Native American Health Center (NAHC) - Outreach, Education & Consultation for Native American Community**

Program Description:

Native American Health Center (NAHC). Native American Health Center's UELP Prevention and Early Intervention program targets urban Native Americans living in Alameda County, and other residents of the surrounding community.

Number of **unduplicated** individuals served in the fiscal year (FY 17/18): 1,671
Number of individual family members (this number will be included in your total above): unknown

Demographics

Report disaggregate numbers served, number of potential responders engaged (for agencies conducting outreach), and number of referrals for treatment and other services for the following categories:

Age Group (Unduplicated)

Children/Youth (0---15)	65
Transition Age Youth (16---25)	30
Adult (26---59)	472
Older Adult (60+)	991
Declined to Answer	113

Race (Unduplicated)

Native American or Alaska Native	1,103
Asian	41
Black or African American	83
Native Hawaiian or other Pacific Islander	
White	44
Other	358
More than one race	
Declined to Answer	42

Ethnicity (Cultural Heritage

Hispanic or Latino as follows:	
Caribbean	
Central American	
Mexican/Mexican---American/Chicano	
Puerto Rican	
South American	
Other	350
Declined to Answer	
Non-Hispanic or Non-Latino as follows:	
African	
Asian Indian/South Asian	
Cambodian	
Chinese	
Eastern European	
European	
Filipino	
Japanese	
Korean	
Middle Eastern	
Vietnamese	
Other	41
More than one	
Declined to Answer	

Primary Languages

English	1,663
Spanish	
Chinese Dialect	
Japanese	
Filipino Dialect	
Vietnamese	
Laotian	
Cambodian	
Sign ASL	
Other Non---English	
Korean	
Russian	
Polish	
German	
Italian	
Mien	
Hmong	
Turkish	
Hebrew	
French	
Cantonese	
Mandarin	
Portuguese	
Armenian	
Arabic	
Samoan	
Thai	
Farsi	
Other Sign	
Other Chinese Dialects	
Ilocano	

Sexual Orientation

Gay or Lesbian	79
Heterosexual or Straight	1,589
Bisexual	1
Questioning or unsure of sexual orientation	
Queer	
Another sexual orientation	
Decline to Answer	2

Disability

Yes	319
Communication Domain:	
Difficulty Seeing	31
Difficulty hearing, or having speech understood	56
Other (specify)	
Mental Domain	126
Physical/Mobility Domain	56
Chronic Health Condition	11
Other	30
No	1,360
Decline to Answer	

Veteran Status

Yes	19
No	1539
Decline to Answer	1,671

Gender

Assigned sex at birth:	
Male	370
Female	1,018
Decline to Answer	283
Current Gender Identity:	
Male	
Female	
Transgender	
Genderqueer	
Questioning or Unsure of Gender Identity	
Another Gender Identity	
Decline to Answer	

Total number of potential responders (outreach audience): 1,671

List type of setting(s) in which the potential responders were engaged and the type(s) of potential responders engaged in each setting:

Type of Setting(s) (ex: school, community center)	**Type(s) of Potential Responders** (ex: principals, teachers, parents, nurses, peers) Separate each type of responder with a comma.
Fair/Community Event Support Group Traditional healing workshop	With family members, community leaders, community members, parents, professionals

Access and Linkage to Treatment Strategy (Required):

Number of individuals with SMI or SED referred to BHCS treatment system (includes county and CBO providers): unknown

List type(s) of treatment referred to:

Through our culturally focused outreach events (as described in the successes section), we are able to provide outreach and recruit new members to our program, provide linkages, and encourage access to NAHC behavioral health care services and other local resources. NAHC's intake coordinator and Peer Specialists are able to provide same day referrals to clinical assessment & psychotherapy when needed; our Youth and Community Health Worker's provide referrals from the prevention groups.

Improving Timely Access to Services for Underserved Populations Strategy (Required):

Target population: Urban Native Americans living in Alameda County, and other residents of the surrounding community.

Number of referrals to a **Prevention** program: unknown
Number of referrals to an **Early Intervention** program: unknown
Number of individuals followed through on referral & engaged in early intervention treatment services: unknown

Average time between referral and participation in treatment: unknown Standard Deviation: unknown

NAHC has been able to collaborate with school-based programming in Oakland to provide onsite prevention group services. We have also partnered with other Native American serving agencies to provide onsite services (such as Washoe TANF and Intertribal Friendship House, and hope to expand on those relationships in the near future.

And/Or:

Number of referrals to **BHCS treatment system (beyond early onset):** unknown
Number of individuals followed through on referral & engaged in treatment: unknown
Average time between referral and participation in treatment: unknown Standard Deviation: unknown

As required for each Prevention Program:

Implementation Challenges:

A major challenge that took place during the 17-18 program year was related to staffing. Over the past year, NAHC's UELP program staff experienced a great amount of turn over, as well as unfortunate medical issues that affected our team's productivity. The Community Wellness Department's director, resigned in August of 2017, and after a long search was finally officially replaced in April 2018. Our lead Intake Coordinator resigned in July 2017, and was replaced in August. The intake worker hired to replace our previous intake worker experienced multiple health issues, and had to take an extended leave of absence. Another team member -- a Peer Counselor, experienced an unfortunate heart condition and is on extended leave as well, and one of our most experienced program members (Youth Coordinator) has been on maternity leave since March. Lastly, the previous Program Manager resigned in January.

Despite the great amount of adversity experienced over the past year, NAHC staff was able to mitigate these challenges by communicating with each other effectively, support each other through cross training, and provide direct service coverage in order to serve the community seamlessly and meet the vast majority of our project goals.

Success:

One of the major accomplishments achieved by NAHC in the past year was the ability to form collaborative relationships with other Native Americans serving agencies in the area. Through these meetings, NAHC has been able create plans to have our Community Health Workers be onsite at important agencies housed in the area such as Intertribal Friendship House, The Women's Lodge, and Washoe TANF, to meet Native American families in places that they might gather outside of NAHC. We are excited about the additional outreach and visibility these partnerships will bring.

Another major accomplishment that NAHC has achieved over the past program year is its consistent success in raising mental health awareness and being able to engage members through our culturally appropriate community events. NAHC hosted a Youth Gathering of Native Americans (GONA), seasonal celebrations, visits with traditional healers, and other gatherings using this framework.

Lessons Learned:

The major lessons learned based on the successes and challenges of our program over the past year are:

From our main success, we learned that collaborating with other agencies in the community, and becoming a more mobile (meeting community members where they are at) workforce is a needed and effective strategy.

From our main challenge, we learned that our team is dedicated and creative, but also needed a more structured and regular meeting time to be able to check-in, discuss work flows, work through challenges, and monitor progress. Measures have been put in place for the upcoming fiscal year to address these issues.

Relevant Examples of Success/Impact:

The 2 events to highlight are:

1. 9/7/17 - Gathering of the Lodges (GoTL) –

The GOTL Event is an Annual Celebration of Sobriety, Recovery, and Native American Culture, and is one of Community Wellness Department's largest & longest on-going events. In fact, this year's event drew around 220 attending Community Members.

Each year, we invite multiple community members, Native American alcohol and drug treatment programs (lodges) and their participants throughout the State of California to celebrate healthy lifestyles, their successes in achieving sobriety, share stories & ideas, and participate in cultural drum/honoring dances and songs, – which all aligns with one of our program philosophies – Culture is Prevention!

2. 12/8/2017 - Community Holiday Gathering

During this holiday themed health fair, NAHC provided youth and family focused activities for the community to participate in. Dental screenings, an outreach booth for Behavioral Health Services, and a member services area for the community to ask questions about medical services, eligibility, make appointments, or register for NAHC services. -True integration!

Over 153 Community Members participated in the event. This event exemplified how our community events are a great opportunity to engage with community in a less formal setting, and raise awareness around NAHC's system of care.

Additional Information:

In this section please include the number of clients and/or contacts you estimate to serve in:
FY 18/19:
FY 19/20:

Any changes you intend to make to your program over the next three fiscal years:

In the upcoming fiscal year, our program goals are to:

- Build capacities of community organizations to integrate culturally responsive wellness strategies into their mental health services.
- Build individual and community resiliency, knowledge, and skills that contribute to the prevention of mental health disorders.
- Increase access to cultural responsive, strength-based mental health outreach, education, early intervention, and treatment services.
- Increase collaboration with community stakeholders and organizations involved with contractor's efforts to serve this underserved ethnic and language population (UELP).
- Prevent mental illness from becoming severe and disabling.
- Further our progress on the Culture is Prevention Project.

Prevention Program
PEI Data Report FY 17/18

As required for each Prevention Program:

MHSA program Number: **PEI 14**

Program Name: **Family Education & Resource Center (FERC); a program of the Mental Health Assoc. of Alameda County**

Program Description:	The Family Education and Resource Center (FERC) is an innovative peer-to-peer program that provides education, advocacy, resources, support and hope to family caregivers of a *loved one* living with a mental health challenge. FERC is operated by the Mental Health Association of Alameda County (MHAAC).

Number of **unduplicated** individuals served in the preceding fiscal year (FY 16/17): **3,022**

Number of individual family members (this number will be included in your total above): **90%; 2,720**

Demographics

Report disaggregate numbers served, number of potential responders engaged (for agencies conducting outreach), and number of referrals for treatment and other services for the following categories: ***FERC will include these demographics in our FY18/19 Report. FERC collects this information, however, we have not been able to query the required specific breakdowns in FY 17/18.***

Access and Linkage to Treatment Strategy (Required):

Number of individuals with SMI or SED referred to BHCS treatment system (includes county and CBO providers): We do our best to refer and connect all of our clients and / or their loved ones to the appropriate and available treatment providers.

List type(s) of treatment referred to:

- ACCESS (we call with our clients to help advocate and navigate the system)
- IHOT
- Crisis Response Program
- ABODE
- Bay Area Community Services

Number of individuals who followed through on referral & engaged in treatment: Many of our clients follow-through on the referrals. Unfortunately, they stop engaging in treatment after 1-3 sessions / meetings with the treatment team due to: not the right fit; the communication or follow-up with the client is poor; or the staff turn-over rate at the treatment program (i.e. case manager, therapist, or psychiatrist).

Average duration of untreated mental illness: 2yrs+
Average time between referral and participation in treatment: varies on the treatment team's availability; average 1-3 months.

Improving Timely Access to Services for Underserved Populations *Strategy (*Required):

Target population: At FERC, we support the family caregivers who have a loved one with a SMI. We help the caregivers to help their loved one get into treatment and support services.

Number of referrals to a **Prevention** program: If it is appropriate, we will 100% make referrals to a Prevention program. We have gone as far as meeting clients and their loved ones at a Wellness Center, participated in groups so they feel more comfortable, we have sat in waiting rooms with the families and their loved one while waiting to see their treatment provider. We have helped consumers to complete benefits paperwork and packets while sitting in the lobby of the treatment facilities.

Number of referrals to an **Early Intervention** program: Same answer as above.

Number of individuals followed through on referral & engaged in early intervention treatment services: Majority of our client's loved ones have followed through on a referral and have given the treatment service a chance. Unfortunately, they stop engaging because they report that the providers lack follow-through or the staff turn-over rate at the treatment program is too much for them to handle. They get tired of being "passed around."

Average time between referral and participation in treatment: 1 -2 months

And/Or

Number of referrals to **BHCS treatment system (beyond early onset):** we call ACCESS together
Number of individuals followed through on referral & engaged in treatment: 1-3 months
Average time between referral and participation in treatment: Beyond early onset: 2-3 months

As required for each Prevention Program:

Implementation Challenges:

Working with family caregivers who may not understand their loved one's diagnosis or challenge(s).
Trying to get help for a client's loved one when they don't think anything is going on with them.
Not being able to get them an appointment without their consent.
Implementing a tracking method to collect all the necessary demographics data.

Success:

Clients have stated the following:
"You're the first person to ask how I was doing. Usually they treat me like I'm invisible."
"I had lost all hope until now."
"My loved one would be in prison or dead if it wasn't for FERC."
"I finally feel heard. I thought I was going to go crazy myself."
"I was nervous when my mom first told me about FERC. I thought, oh great, another person who's going to take my mom's side and tell me what to do. But actually, you really care about me too. You even helped my mom to see what it's like for me and how I'm feeling. That was really great. Thank you."
"Wow! You actually pick-up the phone! Usually I have to leave a voicemail and even then, I never hear back."
"I've never heard you say or refer to a busy caseload as an excuse."
We pride ourselves in our referral process – we make warm transfers vs. passing off a phone number. We know that if we connect our clients with a person on the other side by establishing our own connection with that person, the team we create can be stronger and more solid for our shared clients.

Relevant Examples of Success/Impact:

Our agency reputation for collaborative efforts with other providers in the system and throughout CBOs. It's a huge compliment when other providers refer their colleagues and patients to FERC.
Our success rate at IEP meetings within schools.
We have been a part of CIT since 2011 (the beginning), we have the highest evaluated module for the entire training series. Total law enforcement trained to date (all of CIT, SRJ, CHP and Sheriffs): over 3,000.
Advocating for a client who has a SMI but should have also been a client of the Regional Center; we were able to get them into RC as a client.

Additional Information

In this section please include the number of clients and/or contacts you estimate to serve in:
FY 17/18: 3,298
FY 18/19: 3,528
FY 19/20: 3,775

Any changes you intend to make to your program over the next three fiscal years:

We anticipate growth in staff numbers as well as an increase in the workshops we provide: Family to Family, Family Connections, WRAP for Family Members, Crisis / 5150, and Mental Health 101. We will also be increasing the number of Family to Family classes in Spanish and may host a WRAP for Family Members in Spanish.
We have two offices at the Family Resource Center in Fremont (FRC) – they are planning to relocate their entire hub within the next 2-3 years. I feel that this will also have some impact on our numbers.

FERC OUTREACH EVENTS for FY2017-18				
DATE	**DAY**	**TIME**	**EVENT/LOCATION**	**# Attendees**
July 29	Sat	12-5pm	African American Outreach (workshops: Self-care/Navigating BHCS)	~40
Aug 3	Thurs	9am-12pm	Wright Institute Provider Education Workshop	~35
Aug 9	Wed	6-9pm	Wright Institute Provider Education Workshop	~40
Aug 12	Sat	9am-3:30pm	Suicide Prevention Workshop	~40
Aug 12	Sat	10am-3pm	Allen Temple Annual Health Fair	~500+
Aug 26	Sat	10am-4pm	Acts Full Gospel Health Fair & Auto Show	~100+
Sept 16	Sat	11am-6pm	Black Eyed Pea Festival and Outreach	~200+
Sept 23	Sat	9am-12pm	Out of Darkness Community Walk – San Francisco	~250+
Oct 14	Sat	6am-9am	Out of Darkness Community Walk - Oakland	~150+
Jan 24	Wed	8:30-9:30am	Valley Council on Mental Health	~30+
Jan 27	Sat	10am-4pm	African American Outreach (workshops: Self-care/Navigating BHCS)	~40
Jan 30	Tues	3:30-5pm	FERC presentation at Fremont Unified School District	~30+
Mar 6	Tues	2-3:30pm	Livermore Downtown Association	~50+
Mar 8	Thurs	12-2	MET Mental Health Stakeholder meeting, FERC Presentation	~25+
Mar 24	Sat	10am-2pm	AKA Sorority 8th Annual Health Fair, Lafayette Elementary School 991-14th St., Oakland, CA	~100+
Apr 26	Thurs	11am-3pm	Oakland Housing Authority Health & Wellness, 1327-65th Ave, Oakland	~50+
Apr 28	Sat	12-5pm	African American Outreach (workshops: Self-care/Navigating BHCS)	~65
Apr 28	Sat	10am-3pm	UHURU House Annual Health Fair, Oakland, CA	~50+
May 3	Thurs	6:30-8pm	Washington Hospital MH Ed Series, Mental Wellness Presentation	~30+
May 1	Tues	10-10:30am	FERC Presentation – Livermore PD	~20+
May 4	Fri	10am-2pm	We Move For Health (aka 10x10), 40000 Paseo Padre Pkwy, Fremont, CA	~250+

FERC OUTREACH EVENTS for FY2017-18				
DATE	**DAY**	**TIME**	**EVENT/LOCATION**	**# Attendees**
May 5	Sat	9am-12noon	CSS Health and Wellness Fair, (Lake Merritt area) Oakland	~100+
May 5	Sat	12-3pm	Self-Care for the Caregiver, Cooper AME Church, Oakland	~30
May 8	Tues	10-11am	Multi Service Center Round Table Discussion	~25+
May 10	Thurs	10-11am	Tri-Valley Non-Profit Alliance Meeting	~25+
May 10	Thurs	3-5pm	FERC Presentation, IHOT/AOT Meeting	~15-25
May 12	Sat	9am-3pm	Livermore Office Open House	~50+
May 12	Sat	9am-1pm	Sr. Expo Event, Fremont , CA	~100+
May 17	Thurs	6:30-8pm	Washington Hospital MH Ed Series, Family Support Presentation	~30+
May 19	Sat	10am-1pm	4C's Annual Children's Health Fair,	~50+
May 19	Sat	10am-3pm	Union City Family Center (aka Kids Zone) 725 Whipple Rd, Union City	~75+
May 19	Sat	9am-6pm	27th Annual Livermore Wine Country Downtown Street Fest	~100+
May 20	Sun	9am-6pm	27th Annual Livermore Wine Country Downtown Street Fest	~100+
May 22	Tues	3-4pm	Anthropos Counseling Livermore – Outreach event	~50+
May 23	Wed	6pm-9pm	Wright Institute School of Psychology - presentation	45
May 24	Thurs	9am-12pm	Wright Institute School of Psychology - presentation	40
May 30	Wed	10am-12pm	Mental Health and Self-Care, Housing Authority 935 Union St	30
May 30	Wed	2-4pm	Mental Health and Self-Care, Housing Authority, Lockwood Site	40
June 7	Thurs	9am	In-Service for Telecare (Strides, Stages, Steps and AOT) programs	35
June 23	Sat	10am-7pm	Juneteenth Celebration, 925 Brockhurst St, Oakland	~250+
June 23	Sat	11am-3pm	C.W. Johnson Community Block Party, (Paradise Baptist Church) 9704 Empire Road, Oakland	~50+
June 29	Fri	9am-5pm	Wellness Presentation at POCC Conference	10-20

ON-GOING MONTHLY EVENTS AND COMMITTEE MEETINGS

FREQUENCY	TIME	EVENT	# Attendees
Every 3rd Tues	6-7:30pm	FERC Family/Caregiver Support Group, Oakland	~ 7-13
Every 1st Wed	6-7:30pm	FERC Family/Caregiver Support Group, Oakland	~7-13
Wednesdays	6-8pm	The Family Connections Class (4/19-7/11/2018), Oakland	9
1st Monday, *every other month*	10am-12pm	Older Adult Committee Meeting, BHCS	~15-25
3rd Monday	12-2pm	MH Board Adult Committee Meeting, BHCS	~10-20
Every 2nd Thursday	2-4pm	IHOT/AOT Team Meetings, BHCS	~15-25
Every 4th Tuesday	2-3pm	Suicide Prevention Planning Meeting, Livermore	~5
Every 4th Thursday	2-3:30pm	Training Committee, BHCS	~5-10
Every 1st Friday	10am-11:30am	POCC Oversight and Accountability Committee	~5-15
Every 3rd Friday	12pm-3:30pm	POCC Steering Committee	~15-30
Every month	11:30am-2pm	Crisis Intervention Training (CIT) for Law Enforcement, Oakland Police Dept.	~20-35
Monthly – quarterly (varies)	8:45am-10am	Crisis Intervention Training (CIT) for Dispatchers, OPD	~10-25
Monthly – quarterly (varies)	10:30am-12pm	Crisis Intervention Training (CIT) for Sheriffs, Santa Rita Jail, Dubiln	~25-40

Prevention Program
PEI Data Report FY 17/18

As required for each Prevention Program:

MHSA program: **Number: PEI 20A**

Program Name: **Culturally Responsive PEI programs for the African American Community, TAY Supports (Beats Rhymes and Life (BRL) W.I.S.E. Academy)**

Program Description: BRL cultivates dynamic, culturally responsive services that inspire youth to recognize their own capacity for healing and expression, through community engagement and the therapeutic power of Hip Hop.

Number of **unduplicated** individuals served in the preceding fiscal year (FY 16/17): n/a in 17/18 we served 12 TAY

Number of individual family members (this number will be included in your total above): 0

Demographics

Report disaggregate numbers served, number of potential responders engaged (for agencies conducting outreach), and number of referrals for treatment and other services for the following categories:

Age Group (Unduplicated)

Children/Youth (0---15)	
Transition Age Youth (16---25)	10
Adult (26---59)	
Older Adult (60+)	
Declined to Answer	2

Race (Unduplicated)

American Indian or Alaska Native	
Asian	
Black or African American	11
Native Hawaiian or other Pacific Islander	
White	1
Other	
More than one race	2
Declined to Answer	

Ethnicity (Cultural Heritage)

Hispanic or Latino as follows:	
Caribbean	
Central American	
Mexican/Mexican-American/Chicano	1
Puerto Rican	1
South American	
Other	10
Declined to Answer	
Non-Hispanic or Non-Latino as follows:	
African	10
Asian Indian/South Asian	
Cambodian	
Chinese	
Eastern European	
European	
Filipino	
Japanese	
Korean	
Middle Eastern	
Vietnamese	
Other	2
More than one ethnicity	1
Declined to Answer	

Primary Languages

English	12
Spanish	
Chinese Dialect	
Japanese	
Filipino Dialect	
Vietnamese	
Laotian	
Cambodian	
Sign ASL	
Other Non-English	

Disability

Yes	
Communication Domain:	
Difficulty Seeing	
Difficulty hearing, or having speech understood	
Other (specify)	
Mental Domain	
Physical/Mobility Domain	
Chronic Health Condition	
Other	
No	12
Decline to Answer	

Sexual Orientation

Gay or Lesbian	
Heterosexual or Straight	10
Bisexual	2
Questioning or unsure of sexual orientation	
Queer	
Another sexual orientation	
Decline to Answer	

Veteran Status

Yes	
No	12
Decline to Answer	

Gender

Assigned sex at birth:	
Male	
Female	
Decline to Answer	
Current Gender Identity:	
Male	9
Female	3
Transgender	
Genderqueer	
Questioning or Unsure of Gender Identity	
Another Gender Identity	
Decline to Answer	

Total number of potential responders (outreach audience): 200 +

List type of setting(s) in which the potential responders were engaged and the type(s) of potential responders engaged in each setting:

Type of Setting(s) (ex: school, community center)	**Type(s) of Potential Responders** (ex: principals, teachers, parents, nurses, peers) Separate each type of responder with a comma.
Oakland Public Library System	*Librarians*
Asian Health Services	Administrators
B&G Clubs Oakland	Directors and Line staff
Youth Uprising	Program directors line staff and participants
Impact Hub	Administrators Program coordinators
United Roots	Program directors line staff and participants
East Oakland Building Healthy Communities	Program Counselors
Hope Collaborative	Program directors line staff and participants
East Bay College Fund	Executive Directors and Program Directors
Oakland Kids First	Program Coordinators
Roots Community Health	Program Coordinators
Soulciety	Executive Directors and Program Directors
PEERS	Administrators
HHREC	Administrators
BAYC	Social Work Counselors
Seneca Center	Administration Social Workers and Counselors
Alameda County	ILP Education/Career Specialists
Youth Radio	Executive Director
Bread Project	Executive Director and Program Coordinator
Bay Area Community Services	Service Coordinator Social Workers
Health & Human Resource Education Center	Program Manager
First Place for Youth	Program directors line staff and participants
The Praed Foundation	Executive Staff
Kaiser Permanente	Community Benefits Project Manager III

Number of individuals with SMI or SED referred to BHCS treatment system (includes county and CBO providers): n/a

List type(s) of treatment referred to:

Participants were referred internally to the Case Manager and collaborating agencies for supports around food, housing, academic resources, exploration of healthy relationships, recognizing/understanding depression as well as financial literacy, exploration of sexual identity, and bereavement. Most youth are referred internally and are mild to moderate in terms of need. During the 17/18 fiscal year we worked with 10 youth.

Number of individuals who followed through on referral & engaged in treatment: 10 youth
Average duration of untreated mental illness: NA Standard Deviation: NA
Average time between referral and participation in treatment: NA Standard Deviation: NA

Improving Timely Access to Services for Underserved Populations *Strategy (*Required):

Target population: African American Male
Number of referrals to a **Prevention** program: 10 in our wrap services
Number of referrals to an **Early Intervention** program: 0
Number of individuals followed through on referral & engaged in early intervention treatment services: NA
Average time between referral and participation in treatment: NA Standard Deviation: NA

And/Or

Number of referrals to **BHCS treatment system (beyond early onset):** 0
Number of individuals followed through on referral & engaged in treatment: NA
Average time between referral and participation in treatment: NA Standard Deviation: NA

As required for each Prevention Program:

Implementation Challenges:

Financial supports for participants are a consistent challenge. Specifically seeking supports for college tuition is a challenge Academy Staff are continually assessing internally. Through our County support we are able to provide monthly financial support which is helpful for living and supplemental expenses but we are still faced with figuring out a main source of tuition support for participants who are currently enrolled and for those who are considering going to or returning to school.

Success:

W.I.S.E. Academy was able to provide ongoing workshops on Team building/Leadership, Peer Mentoring, and Artistry development. These classes help allow Academy Fellows to develop skills, self regard, and support their own development. We provided linkages to additional support internally through our Care Coordinator/case manager and externally through program collaborators. Academy Fellows have produced two albums in addition to performing at different venues like Community Health Fairs to our own Community Showcases in Oakland, San Francisco, Fremont and Sacramento.

Lessons Learned:

To help participants gain needed referrals it is important to build community with potential service providers. Having representatives from different agencies offering resources engage with small populations of our youth goes a long way to build trust. It is critical not to introduce transitional age youth to strangers during emergent or critical moments. It is advised to introduce transitional age youth to pre-existing community members.

Relevant Examples of Success/Impact:

One of our participants was honored for her work in creative advocacy by Young Minds Advocacy at the SOMArts Cultural Center in San Francisco for her support in co-founding the Seneca Youth Advisory Board. Another of our participants graduated from the Bread Project and is transitioning into employment as a baker.

Additional Information

In this section please include the number of clients and/or contacts you estimate to serve in:
FY 17/18: 10
FY 18/19: 15
FY 19/20: 40-80

Any changes you intend to make to your program over the next three fiscal years:

Transitioning into direct work with youth in school setting as opposed to at the organization. By the 19/20 fiscal year we hope to serve between 40 to 80 youth.

Prevention Program
Expected Start Date, Spring 2019

As required for each Stigma and Discrimination Reduction Program:

MHSA program Number: **PEI 20D - PENDING**

Program Name: **Culturally Responsive PEI programs- African American Community- Emotional/Empowerment Groups**

Program Description:

Alameda County BHCS is in the process of procuring these services to serve African American populations. Services are expected to begin implementation in Spring, 2019. The Empowerment/Healing Support Group curriculum will be based on African values to support participants in using their voices and experiences to address their mental health needs. The overall goal is the development of a culturally responsive and congruent training that will structure an Empowerment/Healing Support Group engaging community members, including consumers, family members, and caregivers. Approaches shall include techniques and a philosophy of effective community defined practices related to addressing historical racial trauma and maintaining mental wellness. The program shall be grounded in an Afrocentric approach to wellness, values and culture. They are designed by and for community members who identify as African American or of African descent in order to address emotional and psychological stressors affecting this population.

Stigma and Discrimination Reduction Program
Expected Start Date: Spring 2019

As required for each Stigma and Discrimination Reduction Program:

MHSA program Number: **PEI 20E - PENDING**

Program Name: **Culturally Responsive PEI programs- African American Community (Faith-based Programs)**

Program Description:

Alameda County BHCS is in the process of procuring these services to serve African American populations. Services are expected to begin implementation in Spring, 2019. Faith- and Spiritual Healing-based stigma reduction programming will direct services to faith-based/interfaith spiritual leaders, congregations and spiritual/healing communities. The Faith and Spirituality-Based Mental Illness Stigma Reduction Program for African Americans will increase protective factors and decrease risk factors to mitigate the negative impacts of stigma around mental illness. Further, the program will empower African Americans to determine their own unique pathways to psychological wellness and community restoration in private, welcoming, faith practice settings in which they find safety, acceptance and inclusion while respecting the traditions, sacred rituals and customs that affirm their collective dignity.

Prevention Program
Start Date, October, 2019

As required for each Stigma and Discrimination Reduction Program:

MHSA program Number: **PEI 20F**

Program Name: **African American Ethnic Programming – Sobrante Park Violence Prevention - ROOTS**

Program Description:

Implementation of these recently procured services began in October, 2018. Services include:

- Mental health and wellness support for children, youth and families;
- Neighborhood beautification efforts, and
- Career paths and employment readiness and exploration for youth (to be implemented through junior (readiness) and senior (exploration) high school years).

Prevention Program
PEI Data Report FY 17/18

As required for each Prevention Program:

MHSA program Number: **PEI 21B**

Name: **Bay Area Community Services (Towne House, Hedco, Valley, and South County Wellness Centers)**

Program Description:

Wellness Centers provide a welcoming entry point for outpatient services for individuals who are unserved or underserved by the mental health system, including a step-down service for individuals transitioning from BHCS specialty mental health services.
Wellness Centers provide services in an environment of inclusion and, more often than not, are managed and staffed by consumers who provide peer support, wellness, and recovery-oriented education. Wellness Centers use proven curricula that supports the acquisition of the knowledge and skills required for clients to reach their recovery goals.

Number of **unduplicated** individuals served in the preceding fiscal year (FY 16/17): In FY16/17 the BACS Wellness Centers continued to see a high volume of sign-ins (16,437). Additionally, 137 unduplicated individuals received case management.

Number of individual family members (this number will be included in your total above): NA

Demographics

Report disaggregate numbers served, number of potential responders engaged (for agencies conducting outreach), and number of referrals for treatment and other services for the following categories:

Age Group (Unduplicated)

Children/Youth (0---15)	40
Transition Age Youth (16---25)	1,481
Adult (26---59)	13,118
Older Adult (60+)	2,750
Declined to Answer	3,597

Race (Unduplicated)

American Indian or Alaska Native	
Asian/(& Pacific Islander)	2,116
Black or African American	4,232
Native Hawaiian or other Pacific Islander	See above
White	6,771
Other	2,750
More than one race	
Declined to Answer	4,020

Ethnicity (Cultural Heritage)

Hispanic or Latino as follows:	
Caribbean	
Central American	
Mexican/Mexican---American/Chicano	
Puerto Rican	
South American	
Other	
Declined to Answer	2,750
Non---Hispanic or Non---Latino as follows:	
African	
Asian Indian/South Asian	
Cambodian	
Chinese	
Eastern European	
European	
Filipino	
Japanese	
Korean	
Middle Eastern	
Vietnamese	
Other	
More than one ethnicity	
Declined to Answer	

Primary Languages

English	
Spanish	
Chinese Dialect	
Japanese	
Filipino Dialect	
Vietnamese	
Laotian	
Cambodian	
Sign ASL	
Other Non---English	
Korean	
Russian	
Polish	
German	
Italian	
Mien	
Hmong	

Turkish	
Hebrew	
French	
Cantonese	
Mandarin	
Portuguese	
Armenian	
Arabic	
Samoan	
Thai	
Farsi	
Other Sign	
Other Chinese Dialects	
Ilocano	

Sexual Orientation

Gay or Lesbian (LGBTQ)	2,539
Heterosexual or Straight	9,309
Bisexual	
Questioning or unsure of sexual orientation	
Queer	
Another sexual orientation	
Decline to Answer	9,309

Disability

Yes	
Communication Domain:	
Difficulty Seeing	
Difficulty hearing, or having speech understood	
Other (specify)	
Mental Domain	
Physical/Mobility Domain	
Chronic Health Condition	
Other	
No	
Decline to Answer	

Veteran Status

Yes	
No	
Decline to Answer	

Gender

Assigned sex at birth:	
Male	
Female	
Decline to Answer	
Current Gender Identity:	
Male	9.740
Female	5,040
Transgender	
Gender queer	
Questioning or Unsure of Gender Identity	
Another Gender Identity	
Decline to Answer	6,330

Access and Linkage to Treatment Strategy (Required):

Number of individuals with SMI or SED referred to BHCS treatment system (includes county and CBO providers): 800

List type(s) of treatment referred to:

Nearly 800 referrals were made to ACCESS, housing support, and psychiatric services. Of these, nearly 600 referrals were for housing.

Number of individuals who followed through on referral & engaged in treatment: Absent data points are reflective of the population that is receiving services in the wellness centers; i.e. consumers of existing services.

Average duration of untreated mental illness: NA Standard Deviation: NA
Average time between referral and participation in treatment: NA Standard Deviation: NA

Improving Timely Access to Services for Underserved Populations Strategy (Required):

Target population: Individuals who are unserved or underserved by the mental health system. The wellness center is a barrier-free point of entry. Individuals who request or are identified as at risk have access to and are linked to case management, psychiatric support, and employment services. Likewise, case management, psychiatric support, and employment services may connect clients to the wellness center for additional support and socialization. In this way, the wellness centers and the embedded supportive services facilitate linkage to each other providing opportunity for barrier-free access and appropriate linkage to treatment. In the event that the wellness centers are not the most appropriate service for the individual, the staff of the wellness centers may refer clients to the appropriate programs and support the client during the transition. Additionally, the wellness centers have invited and hosted other community providers as well as other BACS teams to our centers to facilitate linkage and access to services. For example, the Health Care for the Homeless and Housing Education Groups run by BACS are found at the wellness centers weekly or monthly. Additionally, individuals in need of psychiatry and case management may be linked to the wellness center of their choosing, if appropriate. The figures below will vary greatly due to the complexity of the linkages provided. For instance, linkage and referral to the health van or housing resources is immediate and no significant time between referral and participation in treatment may occur. Further, this type of linkage and referral will yield 100% participation as the service is provided immediately. Conversely, a referral to psychiatry or psychotherapy may take a week or longer resulting in lower participation rates. Largely, the service linkages are made for individuals who are currently consumers of services in the county.

Number of referrals to a **Prevention** program: Absent data points are reflective of the population that is receiving services in the wellness centers; i.e. consumers of existing services.

Number of referrals to an **Early Intervention** program: Absent data points are reflective of the population that is receiving services in the wellness centers; i.e. consumers of existing services.

Access and Linkage to Treatment Strategy (Required):

Number of individuals followed through on referral & engaged in early intervention treatment services: Absent data points are reflective of the population that is receiving services in the wellness centers; i.e. consumers of existing services.

Average time between referral and participation in treatment: For internal referrals, less than 1 business day. For external referrals, time may vary; i.e. health van is immediate, housing linkages may take days or weeks.
Standard Deviation: NA

As Required for Each Prevention Program:

Implementation Challenges:

In order to create a barrier-free environment, participants are asked to provide demographic information through an iPad kiosk. Unfortunately, the majority of participants have elected not to share demographic information. Thus the data for ethnicity, LGBTQ identification, and disability has been largely statistically insignificant and in such BACS is unable to report on it.

Success:

Prevention programming and intervention were embedded in the peer-support curriculum and case management services. Peer-support services were the first and primary level of engagement for individuals that come to the Wellness Center. By embedding the prevention programming at the peer-support level, there was greater and more immediate access to prevention services with minimal barrier to treatment or linkage to services. The peer support services at the Wellness Centers do not require referral and minimal eligibility check. The Wellness Center case Management program offers a great intensity of clinical service that can integrate treatment planning and identifying potential areas of risk for clients to create targeted preventive interventions.

Individuals linked to services show significant more coping mechanisms to address mental health challenges and demonstrate improved functioning and decrease in hospitalization leading to improved ADLs, physical wellbeing, and socialization. The wellness centers completed a survey addressing these factors and the results are currently being calculated.

Lessons Learned:

BACS will identify a model to collect data points that will maintain the barrier-free model that the wellness centers are known for.

Relevant Examples of Success/Impact:

- All of BACS wellness centers (WC) have increased efforts to connect participants with other resources. In total, nearly 800 referrals were made to ACCESS, housing support, and psychiatric services. Of these, nearly 600 referrals were for housing.
- All WCs reached goals, including:
  - IPS support: 74 participants
  - Census: 2,884 unduplicated individuals
  - More than 17,000 hours of peer counselor/site supervisor direct support to WC participants
- IPS has demonstrated significant successes this year
  - Increase of participants pursuing higher education- South County WC IPS has 5 participants who are currently enrolled in higher education programs.
  - 3 participants enrolled in the BestNow! Program to become peer counselors.
- The wellness centers have formalized MH specific programming to better serve the target population. Groups have been added for Smoking Cessation, Seeking Safety, Medication Management Skill Building, Money Management, and WRAP.
- Housing Education Group has been added to all WCs and have demonstrated strong success. Housing Coordinators present on a specific topic each week and follow the presentation with one-on-one support which includes identifying individualized housing plans and completion of housing forms. Once per month, BALA joins the Housing Education Group and presents on legal matters pertaining to housing.
- The wellness centers continue to partner with FACES, POCC, NAMI, FERC, NA, BestNow!, La Clinica, Bonita House, BALA, HAC, Life Long and Trust Clinic, as well as hosts several AA and NA meetings.
- BACS WCs continue to promote a philosophy of care that is client-centered and strengths-based. To that end, peer counselors meet once per month to deepen their training in engagement, care, risk assessment and management, and methods to improve each center.

Additional Information:

In this section please include the number of clients and/or contacts you estimate to serve in:

FY 18/19: 23,000
FY 19/20: 25,000
FY 20/21: 27,000

Any changes you intend to make to your program over the next three fiscal years: NA

Prevention Program
PEI Data Report FY 17/18

As required for each Prevention Program:

MHSA program Number: **PEI 23**

Program Name: **Post Crisis Peer Mentoring**

Program Description:

Program offers brief low intensity early intervention through peer support to address and promote recovery, and to prevent relapse. This program engages Mentors and Participants whereby each Mentor serves as a facilitator with the Participant on that Participant's path to self-discovery and self-determination.

Number of **unduplicated** individuals served in the preceding fiscal year (FY 16/17): 110

Number of individual family members (this number will be included in your total above): 0

Demographics

Report disaggregate numbers served, number of potential responders engaged (for agencies conducting outreach), and number of referrals for treatment and other services for the following categories:

Age Group (Unduplicated)

Children/Youth (0-5)	
Transition Age Youth (16-25)	30
Adult (26-59)	70
Older Adult (60+)	10
Declined to Answer	

Race (Unduplicated)

American Indian or Alaska Native	1
Asian	10
Black or African American	51
Native Hawaiian or other Pacific Islander	3
White	19
Other	26
More than one race	
Declined to Answer	

Ethnicity (Cultural Heritage)

Hispanic or Latino as follows:	
Caribbean	
Central American	1
Mexican/Mexican-American/Chicano	7
Puerto Rican	
South American	1
Other	2
Declined to Answer	
Non-Hispanic or Non-Latino as follows:	
African	11
Asian Indian/South Asian	2
Cambodian	
Chinese	2
Eastern European	
European	2
Filipino	1
Japanese	
Korean	
Middle Eastern	6
Vietnamese	1
Other	
More than one ethnicity	3
Declined to Answer	1

Primary Languages

English	110
Spanish	
Chinese Dialect	
Japanese	
Filipino Dialect	
Vietnamese	
Laotian	
Cambodian	
Sign ASL	
Other Non---English	
Korean	
Russian	
Polish	
German	
Italian	
Mien	
Hmong	
Turkish	
Hebrew	
French	
Cantonese	

Mandarin	
Portuguese	
Armenian	
Arabic	
Samoan	
Thai	
Farsi	
Other Sign	
Other Chinese Dialects	
Ilocano	

Sexual Orientation

Gay or Lesbian	1
Heterosexual or Straight	11
Bisexual	
Questioning or unsure of sexual orientation	
Queer	
Another sexual orientation	
Decline to Answer	98

Disability

Yes	
Communication Domain:	
Difficulty Seeing	2
Difficulty hearing, or having speech understood	
Other (specify)	
Mental Domain	8
Physical/Mobility Domain	3
Chronic Health Condition	2
Other	
No	6
Decline to Answer	89

Veteran Status

Yes	
No	13
Decline to Answer	97

Gender

Assigned sex at birth:	
Male	9
Female	7
Decline to Answer	94
Current Gender Identity:	
Male	9
Female	7
Transgender	
Gender queer	
Questioning or Unsure of Gender Identity	
Another Gender Identity	
Decline to Answer	94

Number of individuals with SMI or SED referred to BHCS treatment system (includes county and CBO providers): 110

List type(s) of treatment referred to:

Intensive Case Management
Outpatient Therapy
Medication Management/Outpatient Psychiatry
Primary Care
SUD Treatment
PHP

Number of individuals who followed through on referral & engaged in treatment: unknown
Average duration of untreated mental illness: unknown Standard Deviation: unknown
Average time between referral and participation in treatment: 1 week minimum Standard Deviation: unknown

Improving Timely Access to Services for Underserved Populations Strategy (Required):

Target population: Services shall be provided to transition-age youth, adults and older adults being discharged from John George Psychiatric Pavilion (JGPP) inpatient hospital services or crisis stabilization unit, or from the following identified Crisis Residential or Mental Health Rehabilitation Center (MHRC) Programs: Gladman MHRC (Gladman), Jay Mahler Recovery Center (Jay Mahler), Villa Fairmount MHRC (Villa), or Woodroe Place (Woodroe).

And/Or:

Number of referrals to **BHCS treatment system (beyond early onset)**: 110
Number of individuals followed through on referral & engaged in treatment: 110
Average time between referral and participation in treatment: 24 days Standard Deviation: unknown

As required for each Prevention Program:

Implementation Challenges:

All mentors periodically encounter the issue of having a participant without a phone and who is also homeless. This seems to be, and will most likely remain, an on-going challenge. This situation puts a heavier burden on the Participant to be more proactive and stay in contact with the mentor until the Mentor can assist the participant to obtain a free cell phone. At that point, the relationship can become more productive.
Challenge to fully engage Villa Fairmont and Jay Mahler Center with no direct referrals from Gladman/Woodroe Place.

Success:

Exceeded our goal of 45 by establishing connections with 110 participants.
Hope Scale developed and fully implemented from start of fiscal year.

Lessons Learned:

Tracking data from PEI forms needed. For example a log.
Double checking to make sure patient completes the PEI form completely.
Tracking Primary Languages. That is not on the PEI form.

Additional Information:

In this section please include the number of clients and/or contacts you estimate to serve in:
FY 17/18: 110 clients
FY 18/19: 115 clients
FY 19/20: 120 clients

Any changes you intend to make to your program over the next three fiscal years:

Have Mentors be open to working more closely with Participant's family and love ones, at Participant's discretion.

Early Intervention Program
PEI Data Report FY 17/18

As required for each Early Intervention Program:

MHSA program: **PEI 2**

Program Name: **Early Intervention for the Onset of First Psychosis & SMI among TAY- Prevention and Recovery in Early Psychosis (PREP)**

Program Description:

Prevention and Recovery in Early Psychosis (PREP) was originally funded by a BHCS contract in Alameda County in early 2010. The program was operated in a partnership between East Bay Community Recovery Project (EBCRP), Family Service Agency of San Francisco FSASF/Felton Institute, and Mental Health Association of Alameda County (MHAAC) to provide evidence-based treatment and support for transition age youth (TAY) experiencing an initial episode of psychosis.

Number of **unduplicated** individuals served in the preceding fiscal year: 72

Number of individuals at risk (if program served Prevention clients): 0 Number of individuals with early onset: 51

Number of individual family members: Not Collected

Demographics

Report disaggregate numbers served, number of potential responders engaged (for optional Outreach Strategy), and number of referrals for treatment and other services for the following categories:

Age Group (Unduplicated)

Children/Youth (0-15)	0
Transition Age Youth (16-25)	67
Adult (26-59)	5
Older Adult (60+)	0
Declined to Answer	0

Race (Unduplicated)

American Indian or Alaska Native	4
Asian	7
Black or African American	27
Native Hawaiian or other Pacific Islander	3
White	5
Other	22
More than one race	2
Declined to Answer	2

Ethnicity (Cultural Heritage)

Hispanic or Latino as follows:	
Caribbean	0
Central American	3
Mexican/Mexican-American/Chicano	15
Puerto Rican	0
South American	2
Other	0
Declined to Answer	0
Non-Hispanic or Non-Latino as follows:	
African	31
Asian Indian/South Asian	2
Cambodian	0
Chinese	0
Eastern European	0
European	4
Filipino	2
Japanese	0
Korean	0
Middle Eastern	1
Vietnamese	1
Other	1
More than one ethnicity	9
Declined to Answer	1

Primary Languages

English	68
Spanish	2
Chinese Dialect	0
Japanese	0
Filipino Dialect	1
Vietnamese	0
Laotian	0
Cambodian	0
Sign ASL	0
Other Non-English	1
Korean	0
Russian	0
Polish	0
German	0
Italian	0

Sexual Orientation

Gay or Lesbian	1
Heterosexual or Straight	31
Bisexual	5
Questioning or unsure of sexual orientation	1
Queer	1
Another sexual orientation	0
Decline to Answer	33

Disability Status

Yes	6
Communication Domain:	
Difficulty Seeing	0
Difficulty hearing, or having speech understood	0
Other (specify)	
Mental Domain	5
Physical/Mobility Domain	1
Chronic Health Condition	0
Other	0
No	55
Decline to Answer	11

Veteran Status

Yes	0
No	40
Decline to Answer	32

Gender

Assigned sex at birth:	
Male	50
Female	22
Decline to Answer	0
Current Gender Identity:	
Male	48
Female	22
Transgender	0
Genderqueer	0
Questioning or Unsure of Gender Identity	0
Another Gender Identity	0
Decline to Answer	2

As required for each Access and Linkage to Treatment Strategy:

The Program Name: PREP Alameda County
Number of individuals with SMI referred to treatment: 21

List type(s) of treatment referred to:

All clients served at PREP Alameda were referred through the BHCS TAY Access Team (TAT). A few individuals who did not meet eligibility criteria and/or did not engage in services at PREP Alameda were reconnected with TAT. TAT is formed by clinical providers in the TAY System of Care and holds weekly meetings to discuss referrals and planned linkages to services within the system of care.

Due to leadership change in PREP Alameda, with transition from EBCRP to Felton/FSASF that included new EHR, we are unable to report on quantitative data to reflect average time between referral and participation in treatment. However, we had positions open for long periods of time resulting in delay in processing referrals and consequently engaging clients in treatment.

Number of individuals followed through on referral & engaged in treatment: 21
Average duration of untreated mental illness: Data not available Standard Deviation: N/A
Average time between referral and participation in treatment: Data not available Standard Deviation: N/A

As required for each Improve Timely Access to Services for Underserved Populations Strategy:

Identify target population: Individuals within two years of onset of psychotic symptoms
Number of referrals to a **Prevention** program: N/A
Number of individuals followed through on referral & engaged in treatment: N/A

Average time between referral and participation in treatment: N/A Standard Deviation: N/A
Number of referrals to an **Early Intervention** program: N/A
Number of individuals followed through on referral & engaged in treatment: 51

Average time between referral and participation in treatment: N/A Standard Deviation: N/A

And/Or

Number of referrals to **treatment beyond early onset:** 21
Number of individuals followed through on referral & engaged in treatment: N/A
Average time between referral and participation in treatment: N/A Standard Deviation: N/A

As required for each Early Intervention Program:

Implementation Challenges:

During this fiscal year, PREP Alameda navigated through significant changes that included:

- Reversing the process of becoming a Full Service Partnership model program (this created issues with identifying and implementing specific reporting requirements);
- Sunset of partnership between EBCRP and Family Service Agency of SF/Felton Institute;
- Preparations to transition leadership to Family Service Agency of SF/Felton Institute.

At program level, staff turnover and long periods with multiple vacant positions created challenges that resulted in smaller caseloads, less referrals, and more reliance on other community resources for medication support. Despite these challenges, in May 2018 PREP Alameda held the annual graduation ceremony with record attendance in comparison to previous years, and in June 2018, the team promoted a well-received orientation session for new families. We also had a stellar IPS Fidelity Review, as described in previous sessions.

Successes:

FY 2017-18 was also a year of remarkable successes, big and small, for our program participants:

- A young woman experiencing auditory hallucinations and struggling with hard drugs began working with PREP in late 2016. After several stays at numerous residential treatment facilities, she desired change, but was unsure on the necessary steps to move forward. Our Care Advocate had also struggled with drugs in the past and was able to relate to this young woman. Over time, the two developed a close, supportive relationship. Our Care Advocate supported her in attending Narcotics Anonymous as well as taking her to Laney College to enroll for this upcoming fall semester.
- A young woman struggled with her symptoms of psychosis and had to delay her plans of going to college. She began attending weekly Group Activities where our Care Advocate would facilitate discussions and foster important life skills to be independent (e.g. cooking, learning how to use public transportation). This young lady became more vocal during Group Activities and took on a speaking role to educate others about her own experiences with psychosis. She developed her public speaking skills and was able to present to a group of graduate students in clinical psychology earlier in the summer. She has now graduated from our program and is enrolled at Cal State East Bay.
- A young woman who is discharging from our program working almost full-time and completed all the steps to make the transition to Cal State University East Bay from a local community college.
- A young man who has been working full time for almost a year as a landscaper at a cemetery.
- A young man looking for work who does not want to apply for SSI because he believes employment is a better path to what he wants in life.

Lessons Learned

At program level, staff turnover and long periods with multiple vacant positions created challenges that resulted in low census, less referrals, and more reliance on community resources to ensure clients had access to necessary services. PREP Alameda will implement strategies to improve access to services for underserved populations by maintaining a multidisciplinary team that is closely representative of the population served, with most individuals identified as African-American (50%), Hispanic/Latino (33%), and White/Caucasian (17%). As we rebuild the team, we will actively recruit bilingual/bicultural individuals that are representative of the populations we serve.

Relevant Examples of Success/Impact:

We worked closely with the TAY Access Team to ensure clients had access to services regarding of our staffing issues.

TAT providers collaborate frequently to ensure all clients have timely access to services, and we collaborated closely with IHOT to ensure potential referrals to PREP received outpatient services while waiting to be connected with coordinated specialty care for early psychosis.

Prevention Program
PEI Data Report FY 17/18

As required for each Prevention Program:

MHSA program Number: **PEI 3**

Program Name: **Mental Health for Older Adults, Geriatric Assessment and Response Team (GART)**

Program Description: **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.

Number of **unduplicated** individuals served in the preceding fiscal year (FY 16/17): 53

Number of individual family members (this number will be included in your total above): Data Unknown

Demographics

Report disaggregate numbers served, number of potential responders engaged (for agencies conducting outreach), and number of referrals for treatment and other services for the following categories:

Age Group (Unduplicated)

Children/Youth (0---15)	
Transition Age Youth (16---25)	
Adult (26---59)	2
Older Adult (60+)	39
Declined to Answer	12

Race (Unduplicated)

American Indian or Alaska Native	
Asian	16
Black or African American	5
Native Hawaiian or other Pacific Islander	
White	13
Other	7
More than one race	
Declined to Answer	12

Ethnicity (Cultural Heritage)

Hispanic or Latino as follows:	
Caribbean	
Central American	
Mexican/Mexican-American/Chicano	
Puerto Rican	
South American	
Other	53
Declined to Answer	
Non-Hispanic or Non-Latino as follows:	
African	
Asian Indian/South Asian	2
Cambodian	
Chinese	14
Eastern European	
European	
Filipino	
Japanese	
Korean	
Middle Eastern	
Vietnamese	
Other	37
More than one ethnicity	
Declined to Answer	

Primary Languages

English	19
Spanish	1
Chinese Dialect	13
Japanese	
Filipino Dialect	
Vietnamese	
Laotian	
Cambodian	
Sign ASL	
Other Non-English	6
Korean	
Russian	
Polish	
German	
Italian	
Mien	
Hmong	
Turkish	
Hebrew	
French	
Cantonese	
Mandarin	
Portuguese	
Armenian	
Arabic	
Samoan	
Thai	
Farsi	2
Other Sign	
Other Chinese Dialects	
Ilocano	
Decline to Answer	12

Sexual Orientation

Gay or Lesbian	
Heterosexual or Straight	
Bisexual	
Questioning or unsure of sexual orientation	
Queer	
Another sexual orientation	
Decline to Answer	53

Disability

Yes	
Communication Domain:	
Difficulty Seeing	
Difficulty hearing, or having speech understood	
Other (specify)	
Mental Domain	
Physical/Mobility Domain	
Chronic Health Condition	
Other	
No	
Decline to Answer	53

Veteran Status

Yes	
No	
Decline to Answer	53

Gender

Assigned sex at birth:	
Male	
Female	
Decline to Answer	53
Current Gender Identity:	
Male	14
Female	27
Transgender	
Genderqueer	
Questioning or Unsure of Gender Identity	
Another Gender Identity	
Decline to Answer	12

Access and Linkage Strategy (Required)

Number of individuals with SMI or SED referred to BHCS treatment system (includes county and CBO providers): 53

List type(s) of treatment referred to:

Outpatient psychotherapy, outpatient psychiatry, neuropsychology, inpatient geriatric & non-geriatric providers for additional assessment & treatment, day-treatment programs and drop-in socialization and day rehabilitation centers, field-based case management programs, peer-based support groups for older adults, friendly visitors, culturally responsive and language-specific mental health providers, recovery-oriented substance abuse programs and providers, housing & homeless resources that cater to either older adults or individuals with mental health needs. Referrals to Alzheimer's Association are made for individuals (& their families) who have co-occurring dementia

Number of individuals who followed through on referral & engaged in treatment: unknown
Average duration of untreated mental illness: one month to 40+ years Standard Deviation: NA
Average time between referral and participation in treatment: 24-72 hours Standard Deviation: NA

Improving Timely Access to Services for Underserved Populations *Strategy (*Required):

Target population: N/A
Number of referrals to a **Prevention** program: 0
Number of referrals to an **Early Intervention** program: 0
Number of individuals followed through on referral & engaged in early intervention treatment services: 0

Average time between referral and participation in treatment: NA Standard Deviation: NA

And/Or

Number of referrals to **BHCS treatment system (beyond early onset):** 33 (actively linked to services, aka, warm-hand off)
Number of individuals followed through on referral & engaged in treatment: unknown
Average time between referral and participation in treatment: Approximately 3 days Standard Deviation:

As required for each Prevention Program:

Implementation Challenges:

We continue to work toward more successful outcomes with primary care referrals. Clinicians have consistently found that while clients may agree to mental health services and GART outreach when introduced by their primary care provider, they decline when a clinician reaches out. We've attempted to mitigate this issue by working toward stronger relationships with primary care providers (PCP). We've also suggested that, when possible & appropriate, PCP coordinate with GART to meet client at doctor's office to facilitate referrals.

On 5/8/18 members of the GART program met with the Consortium of Behavioral Health Directors of Alameda County's Federally Qualified Health Centers. The GART Team's Clinical Supervisor will follow up with their coordinator on developing partnerships within the next year. The GART team would like to explore the possibility of embedding a clinician within a primary care setting.

In 2017 the GART program lost both its Spanish-speaking & Mandarin-speaking clinicians. This loss continues to necessitate more frequent use of phone & field-based interpreters. We believe that these staffing changes may also have led to an ongoing decrease in referrals from Asian Health and Tiburcio Vasquez FQHC providers.
GART continues to struggle with supporting older adults who face problematic gaps within the community and behavioral health system of care. For example: identifying appropriate resources for individuals with co-occurring dementia or who have skilled nursing needs, locating safe and healthy housing at an affordable price point and supporting individuals who have private insurance, Medicare-only or a high share of cost.

Success:

All GART services are provided in the comfort and convenience of the client's preferred community setting (e.g. home, café or senior center). Doing so removes barriers to mental health services due to such things as mobility issues, limited access to transportation, social isolation and stigma. GART clinicians begin their work by establishing trust and developing a therapeutic relationship with each client as well as their loved ones. This valuable connection facilitates engagement in services, development of client-centered goals and a productive termination process.
Well-trained clinicians have expedited services to clients by completing assessment process and documentation requirements within the first or second meeting. Once medical necessity is determined, Medi-CAL services can be provided and billed for. This has increased GART's provision of psychotherapy, brokerage and medication support services over the past year. Over the past year, the GART team has increased their use of treatment plan development which has lengthened service provision an average of 3-6 months when client need is indicated.
Over the past year, GART staff had 35 outreach activities throughout Alameda County and connected with an estimated 1900 individuals (clients, families, professionals) at Health Fairs, Senior Services events and local provider locations (e.g. APS, hospitals, day-treatments).

GART clinicians have become regular presenters for the Alameda County Social Services Training and Consulting Team (TACT). They have provided valuable information about MHSA, the GART program and the mental health needs of older adults as part of an induction class for new public guardianship, public conservator and APS & IHSS workers. GART is also regularly presenting to Cal State East Bay nursing students and Meals on Wheels. These presentations benefit and strengthen working relationships with the above mentioned programs because we frequently serve the same clients.

GART hosted its first MSW intern from the University of California at Berkeley, School of Social Welfare for the 2017-18 school year. The participant was a first-year student within the Aging specialization. He accompanied clinicians in the field and provided some brief treatment to Spanish-speaking clients. As part of his research project, he reviewed the GART evaluations and made recommendations for an improved tool to assess client satisfaction.

Lessons Learned:

Although over 50 clients' were opened, GART had over 150 contacts; acting as its own portal allows the public to have immediate access to support, regardless of eligibility. In addition to 900 hours of direct service, GART provided an additional 940 MAA hours.

Relevant Examples of Success/Impact:

Vignette I

Daughter called GART program concerned about her 75 y/o mother who won't attend church anymore, stopped visiting friends and began avoiding family gatherings – all of which used to bring her joy.
GART LCSW clinician & RN visited client in her home & conducted a bio, psycho-social & medical assessment. They learned that although client had been widowed for many years, she recently lost a close friend. It was also revealed that client has been having dizzy spells and fell once in the past month. Because of this, she has become fearful to leave the house. She also didn't want to burden her daughter, who has young children & works full-time, with requests for help. GART RN reviewed medications & suspects that due to (anti-cholinergic) side effects of one of her medications, client may be getting dehydrated which can lead to increased dizziness. She reached out to client's primary care physician to consult. Clinician provided brief therapy, utilizing cog-bx techniques to address issues of grief & made referrals for ongoing supports. Referrals to both transportation resources and Senior Injury Prevention Programs were provided in order to prevent falls and promote client's independence. Client responded well to therapeutic strategies. She became less isolated and eventually agreed to weekly, in-home meetings from the Friendly Visitors program. She and daughter began to check in regularly and attending church together once again.

Vignette II

Treatment provider from day program called GART program concerned about a long-time client with chronic, paranoid schizophrenia. This client's psychiatric and medical issues have been stable for years and she was described as a well-loved, outgoing participant in the program. Recently, however, she seemed to become more paranoid & delusional – reporting that the board and care home where she'd lived for a decade was "shutting down". GART LCSW clinician visited client at home to develop rapport & begin assessment. It quickly became clear that client's concerns were reality-based and that, in fact, the board and care was closing. Although this information had been conveyed to residents, client was confused and anxious about what to do. Because client had few social supports beyond those at the day program, GART clinician began work to re-connect her to case management services. Clinician also initiated referrals to housing resources and advocated for clients rights as a resident. At discharge, warm hand-off was made to an older adult ACT case management team. They assisted her with a move to a new residence and introduced her to additional, supportive community resources (e.g. socialization opportunities, endocrinologist, and assistive technologies for hearing impairment). Client continued with day program and returned to former baseline.

Additional Information

In this section please include the number of clients and/or contacts you estimate to serve in:
FY 17/18: 52
FY 18/19: 52
FY 19/20: 52

Any changes you intend to make to your program over the next three fiscal years:

The GART team has found that complicating medical, social and psychiatric factors adds to the time it takes to complete a thoughtful differential diagnosis for geriatric clients. Additionally, limited older adult specific community resources means that warm hand-offs take longer to identify and facilitate. Finally, the GART team has found that initial refusal of mental health services due to stigma &/or long standing, untreated trauma lengthens the engagement period as well. In order to improve services to older adults, the GART team has learned that more time leads to better care. Beginning July 2018, the GART program will expand services up to 6 months. The new timeline widens the potential service provision from the original 30-60 day parameter. All services and timelines are based upon client need. Justification and rationale will be provided within an individualized client treatment plan which must be completed before planned services can be provided.

Early Intervention Program
PEI Data Report 17/18

As required for each Early Intervention Program:

MHSA program: Number: **PEI 17A/B**

The Program Name: **TAY Resource Centers (Youth UpRising)**

Program Description: Youth Uprising (YU) provides peer group sessions, counseling for healing and health, case management and holistic wellness services to youth, ages 13-25 in an accessible community setting.

Number of **unduplicated** individuals served in the preceding fiscal year: 340

Number of individuals at risk (if program served Prevention clients): _____

Number of individual with early onset: 1

Number of individual family members: 3

Demographics

Report disaggregate numbers served, number of potential responders engaged (for optional Outreach Strategy), and number of referrals for treatment and other services for the following categories:

Age Group (Unduplicated)

Children/Youth (0--15)	87
Transition Age Youth (16--25)	251
Adult (26--59)	2
Older Adult (60+)	
Declined to Answer	

Race (Unduplicated)

American Indian or Alaska Native	4
Asian	3
Black or African American	221
Native Hawaiian or other Pacific Islander	6
White	7
Other	80
More than one race	13
Declined to Answer	6

Ethnicity (Cultural Heritage)

Hispanic or Latino as follows:	
Caribbean	
Central American	1
Mexican/Mexican--American/Chicano	40
Puerto Rican	
South American	
Other	26
Declined to Answer	25
Non--Hispanic or Non--Latino as follows:	
African	124
Asian Indian/South Asian	2
Cambodian	
Chinese	
Eastern European	4
European	
Filipino	
Japanese	
Korean	
Middle Eastern	
Vietnamese	
Other	42
More than one ethnicity	6
Declined to Answer	70

Primary Languages

English	310
Spanish	26
Chinese Dialect	
Japanese	
Filipino Dialect	
Vietnamese	
Laotian	
Cambodian	
Sign ASL	
Other Non--English	4.00
Korean	
Russian	
Polish	
German	
Italian	
Mien	
Hmong	
Turkish	

Sexual Orientation

Gay or Lesbian	6
Heterosexual or Straight	266
Bisexual	12
Questioning or unsure of sexual orientation	4
Queer	3
Another sexual orientation	1
Decline to Answer	48

Disability

Yes	17
Communication Domain:	
Difficulty Seeing	
Difficulty hearing, or having speech understood	
Other (specify)	1
Mental Domain	7
Physical/Mobility Domain	1
Chronic Health Condition	
Other	
No	306
Decline to Answer	17

Veteran Status

Yes	
No	330
Decline to Answer	10

Gender

Assigned sex at birth:	
Male	151
Female	186
Decline to Answer	3
Current Gender Identity:	
Male	149
Female	184
Transgender	1
Gender queer	1
Questioning or Unsure of Gender Identity	2
Another Gender Identity	
Decline to Answer	3

As required for each Access and Linkage to Treatment Strategy:

Number of individuals with SMI referred to treatment: 7

List type(s) of treatment referred to:

HIP, Crisis Line, CASA, Pathway to Wellness Oakland, Access Line, TAT meeting, Covenant House and Woodrow Place were all places this program used over the year for the higher need clients. They also did a great job at screening clients on the front end before even providing services to ensure that they were an appropriate fit for the agency. In the future for those folks screened out on the front end they'll do a better job of keeping track of who they are and where they go. This program also tightened up their trauma informed lens and skill set so that all staff were able to interact with youth in a safe way. Because of this, their in- house program referrals did a great job at keeping the young adults stabilized and preventing the need for a higher level of care.

Number of individuals followed through on referral & engaged in treatment: 3
Average duration of untreated mental illness: 90.00 Standard Deviation: NA
Average time between referral and participation in treatment: 7.00 Standard Deviation: NA

As required for each Improve Timely Access to Services for Underserved Populations Strategy:

Identify target population: Ages 13-24
Number of referrals to a **Prevention** program: 272
Number of individuals followed through on referral & engaged in treatment: NA
Average time between referral and participation in treatment: 4.00 Standard Deviation: NA

Number of referrals to an **Early Intervention** program: 4
Number of individuals followed through on referral & engaged in treatment: 4
Average time between referral and participation in treatment: 4.00 Standard Deviation: NA

And/Or

Number of referrals to **treatment beyond early onset:** 6
Number of individuals followed through on referral & engaged in treatment: 2
Average time between referral and participation in treatment: 5.00 Standard Deviation: NA

Describe ways your agency encouraged access to services and follow--through on referrals:

We continued to link members to internal and external programs, throughout the year. Youth that are connected to our internal programs such as Sister Circle, Man Up, Five Keys, and Music Production have immediate access and a higher follow through rate. Additionally, all of the young people that participate in our groups/programs have immediate access to a culturally responsive clinician on a regular basis which continues to decrease the stigma around gaining support from a mental health professional. We also hired a case manager to support follow through with linkages and handling basic needs/task. We are doing a good job of putting intentional effort towards building real partnerships to improve collaboration and these stronger partnerships support warm hand-offs and increased follow through.

As required for each Early Intervention Program

Implementation Challenges:

Although we were sending documentation records in with our invoices to support the work being done, the info was not going to the correct folks and much of the info around our community contact support was not captured. Many of the youth are homeless and couch surfing which creates challenges such as increased crime, inability to follow through and increased sense of hopelessness, anxiety and depression. As an agency we are doing the best we can to support the youth by providing resources and mental health support. We have a growing need for a clinical case manager and a case manager to assist the members to follow through on referrals in particular those that need preventive services to reduce risk of developing SMI. We have seen folks with a high level of mental health needs but functioning at a high enough capacity to refuse traditional services and/or fall through the cracks and not benefit from care.

Successes:

We continue to build relationships with the young people and membership has not only been consistent but the young folks are making use of the mental health services. We trained staff in Mental Health First Aid and Trauma Informed Care. We joined the Breakthrough Series Collaborative to partner with other CBO's to ensure that we support the community with an approach that recognizes trauma and the needs of the community. We continue to build strong partnerships to maintain ourselves as a community anchor. We maintained a consistent staffing pattern which allowed the youth and young adults to build healthy safe relationships. We continue to strengthen our in-house resources to allow us to successfully provide the youth with what they need.
We have begun building our Salesforce database platform to house all of our information in one place to also produce necessary reports.

Lessons Learned:

We learned that social media is a big part of the lives of young folks and with social media we can impact many more. Continued collaboration is key in-house and with outside partners. We learned using the youth to drive programming is key to their success and participation. Having a good data tracking system is vital.

Relevant Examples:

We have begun to establish a youth advisory board to ensure that the program activities are reflective of what the members need and want. We have hired a youth intern to maintain the social media platform. We have hired an Early Childhood Systems Manager to support the need of our members who have begun having children and need greater support.

Additional Information

We met all of our yearly program goals. We maintained a minimum of 2 ongoing groups. In addition to our Dialectical Behavioral Therapy group, we maintained Sister Circle and Makers Space where we focused on topics such as grief, depression, anxiety, PTSD, self-care, restorative justice, etc.

We met the goal of 45 unduplicated clients and completed CANS/ANSA screenings for those clients.

We utilized TAT as a resource for our clients needing higher level services. We developed a process to check for and enroll youth into Medi-Cal. We attended and loved the monthly TAY directors meeting and also invited other staff to learn and participate from the trainings.

We provided activities to reduce stigma around mental health: Domestic Violence and safe relationships (in partnership with a safe place), Mental Health forums (in partnership with CHO), Pyrography (wood burning) event to discuss mental health healing through art. We surpassed 12 hours of staff training: DBT training (8hrs), Triple P parenting program training (24hrs), TIS training (4 hours), Integrative treatment of Complex trauma for Adolescents (8hrs), Supporting African American Trans community with substance use (8hrs), Mental Health First Aid (8 hours).

Outreach for Increasing Recognition of Early Signs of Mental Illness Program
PEI Data Report FY 17/18

As required for each Outreach for Increasing Recognition of Early Signs of Mental Illness Program:

MHSA program Number: **PEI 1C**

The Program Name: **Early Childhood Mental Health Outreach & Consultation**

Program Description: Early Childhood Mental Health Consultation to teachers and directors in low income preschool programs utilizing the Stands of Practice. Consultation with parents when additional support and linkages are indicated.

Total number of potential responders: **31**

List type of setting(s) in which the potential responders were engaged and the type(s) of potential responders engaged in each setting:

Type of Setting(s) (ex: school)	**Type(s) of Potential Responders** (ex: principals, teachers, parents, nurses) Separate each type of responder with a comma.
Preschools	Directors, teachers, and site managers

Demographics

Report disaggregate numbers served, number of potential responders engaged, and number of referrals for treatment and other services for the following categories:

Age Group

Children/Youth (0---15)	
Transition Age Youth (16---25)	2
Adult (26---59)	25
Older Adult (60+)	4
Declined to Answer	

Race

American Indian or Alaska Native	
Asian	6
Black or African American	10
Native Hawaiian or other Pacific Islander	
White	3
Other	12
More than one race	
Declined to Answer	

Ethnicity (Cultural Heritage)

Hispanic or Latino as follows:	
Caribbean	
Central American	3
Mexican/Mexican---American/Chicano	3
Puerto Rican	
South American	2
Other	
Declined to Answer	
Non---Hispanic or Non---Latino as follows:	
African	2
Asian Indian/South Asian	
Cambodian	1
Chinese	3
Eastern European	
European	3
Filipino	
Japanese	
Korean	
Middle Eastern	
Vietnamese	2
Other	12
More than one ethnicity	
Declined to Answer	

Primary Language

English	17
Spanish	8
Chinese Dialect	2
Japanese	
Filipino Dialect	
Vietnamese	2
Laotian	
Cambodian	1
Sign ASL	
Other Non---English	1
Korean	
Russian	
Polish	
German	
Italian	
Mien	
Hmong	
Turkish	
Hebrew	
French	
Cantonese	
Mandarin	
Portuguese	
Armenian	
Arabic	
Samoan	
Thai	
Farsi	
Other Sign	
Other Chinese Dialects	
Ilocano	

Sexual Orientation

Gay or Lesbian	2
Heterosexual or Straight	29
Bisexual	
Questioning or unsure of sexual orientation	
Queer	
Another sexual orientation	
Decline to Answer	

Disability

Yes	
Communication Domain:	
Difficulty Seeing	
Difficulty hearing, or having speech understood	
Other (specify)	
Mental Domain	
Physical/Mobility Domain	
Chronic Health Condition	2
No	29
Decline to Answer	

Veteran Status

Yes	
No	
Decline to Answer	

Gender

Assigned sex at birth:	
Male	1
Female	30
Decline to Answer	
Current Gender Identity:	
Male	
Female	
Transgender	
Gender queer	
Questioning or Unsure of Gender Identity	
Another Gender Identity	
Decline to Answer	

Describe ways your program encouraged access to services and follow---through on referrals:

We have not yet had the opportunity to do so but we will be able to meet with teachers and parents to support children by providing prevention and early intervention strategies for children in the classroom and at home. We will also be able to identify children who need additional mental health, speech and language, and occupational therapy support.

As required for each Outreach for Increasing Recognition of Early Signs of Mental Illness Program:

Implementation Challenges:

Challenges included hiring a bi-lingual Spanish consultant with previous experience in a timely manner. We needed to hire someone with no early childhood experience and train them on early childhood mental health consultation as well as early childhood development.

Another challenge has been to find sites that serve the very low-income underserved populations that have NEVER had previous mental health consultation services. Many teachers have not have received consultation but other teachers in the classroom may have. Other sites were very interested but did not meet the state or federally subsided requirement.

Success:

We have established a few sites that are very excited to receive services and are in great need. We have established some very promising relationships. We have trained 2 very skilled diverse consultants who are ready to begin service provision. We have created some excellent protocols for implementation and established evaluation tools. Our other consultants and supervisors have been engaged to participate in the evaluation as well.

Lessons Learned:

It always takes more time to develop a program than expected.

Relevant Examples of Success/Impact:

We will have more information once we begin full services.

Additional Information:

In this section please include the number of outreach contacts you estimate to provide in:
FY 17/18: 15 more responders and 20 parents and 20 children
FY 18/19:
FY 19/20

Any changes you intend to make to your program over the next three fiscal years: NA

Outreach for Increasing Recognition of Early Signs of Mental Illness Program
PEI Data Report FY 17/18

As required for each Outreach for Increasing Recognition of Early Signs of Mental Illness Program:

MHSA program Number: **PEI 1D**

The Program Name: **Unaccompanied Immigrant Youth Outreach (UIY)**

Program Description:

The Unaccompanied Immigrant Youth (UIY) program provides linguistically appropriate and culturally sensitive mental health services and interventions for youth who immigrated to the United States without the accompaniment of a parent. The program provides trauma-focused and family-oriented treatment to Unaccompanied Immigrant Youth families through four Clinicians and two Case Managers who serve as a mobile unit providing services at schools and in the community throughout Alameda County.

Total number of potential responders: 190

Demographics

Report disaggregate numbers served, number of potential responders engaged, and number of referrals for treatment and other services for the following categories **(*Demographic Information Not Available)**:

Number of referrals to a prevention program - 30 Referrals

- Number of individuals followed through on referral & engaged in prevention services 30 Received Services
- Average time between referral and participation in prevention services On average, for those who received services, it was 0.57 days between referral and receipt of services
- Standard Deviation For those who received services there was a standard deviation of 3.04 days

Number of referrals to an early intervention program - 160 Referrals

- Number of individuals followed through on referral & engaged in prevention services 172 Received Services
- Average time between referral and participation in prevention services On average, for those who received services, it was 1.82 days between referral receipt of services
- Standard Deviation For those who received services there was a standard deviation of 6.62 days

Number of referrals to a treatment program - 20 Referrals

- Number of individuals followed through on referral & engaged in prevention services 6 Received Services
- Average time between referral and participation in prevention services On average, for those who received services, it was 2.37 days between referral receipt of services
- Standard Deviation For those who received services there was a standard deviation of 11.26 days

As required for each Outreach for Increasing Recognition of Early Signs of Mental Illness Program:

Implementation Challenges:

As with the previous reports, the students being served by this program often experience many complications aside from and which often exacerbate mental health symptoms. For example, many experience insecure housing, lack of food (especially healthy foods), inadequate clothing, few school supplies, difficulties with transportation, and a need for hygiene products.

Most of the students seen by staff in this program also have difficulty accessing legal supports and thus face immigration uncertainty, which is also very stressful.

Staffing is also difficult as the positions require clinical training, being bilingual, and experiences with immigrant populations.

Success:

Staff members were able to see and provide services to a great many students over the course of the year and reported many positive anecdotes of helping students to overcome emerging mental health needs. As can be seen above in the referral data, however, helping students get connected to specialty mental health services when needed was often difficult; most students are still waiting to be seen, largely due to the lack of Spanish-speaking service providers and the capacity of service providers overall.

Staff were also able to continue to build relationships with school staff and administrators, enhancing their ability to connect with students who met our service criteria and to do so earlier in the year or closer to when their needs became apparent to school staff.

Lessons Learned:

We intend to continue to track successes with students and our assessments regarding same in order to improve outcomes moving forward.

We will also be encouraging staff to engage further will school sites such that administrators and educators may better understand the unique needs of our students.

Relevant Examples of Success/Impact:

We experienced success in the perception that students had regarding the quality and usefulness of their services. When surveyed for their satisfaction with services, on average 91% of responses indicated that a student was either in strong or partial agreement with a statements (note: all statements were positively framed, such as “In general, I am satisfied with the services I received”).

We also successfully partnered with another organization – Community Impact Lab – who were able to provide our students with care packages containing needed hygiene, clothing, and food items.

Additional Information

Please include the number of outreach contacts you estimate to provide in:
FY 18/19 3000
FY 19/20 3000
FY 20/21 3000

Describe any changes you intend to make to your program over the next three fiscal years:

The UIY program is showing itself to be an essential support for the students we serve, individuals who would otherwise either not be served at all or not receive services that account for their particular needs and circumstances. We continue to hope to provide more support for access to basic needs and, ideally, expand to provide services to more students throughout Alameda County.

Outreach for Increasing Recognition of Early Signs of Mental Illness Program
PEI Data Report FY 17/18

As required for each Outreach for Increasing Recognition of Early Signs of Mental Illness Program:

MHSA program Number: **PEI 1E**

The Program Name: **School-Based Mental Health Outreach**

Program Description:

The Outreach for School-Based Health Centers program is designed to bring awareness and information about how to identify early signs of mental illness in youth and connect those in need with the mental health services offered through the School-Based Health Centers. Efforts are targeted to reach potential responders and youth.

Total number of potential responders: 113 responders & 1,138 youth = 1,251

List type of setting(s) in which the potential responders were engaged and the type(s) of potential responders engaged in each setting:

Type of Setting(s) (ex: school)	**Type(s) of Potential Responders** (ex: principals, teachers, parents, nurses) Separate each type of responder with a
Suicide Awareness & Prevention Events	Teachers, School Resource Officer, Students (10 responders & 180 youth)
District LGBTQ Roundtable	District Staff, Teachers, Community Members (5 responders & 4 youth)
Student Attendance Review Board	District Students Services Personnel, Resource Officer, Principals, Parents, Nurses (7 responders)
Meetings with Admin & Counselors	Principals, Vice Principals, Deans, School Counselors (24 responders)
School Intervention Team	Principal, Vice Principal, Equity Coordinator, Intervention Lead, Teachers, Special Education, counselors (11 responders)
Mental Health Matters Class	Teacher, Students (1 responder & 62 youth)
City Collaborative	Superintendent, County Supervisor, City Staff, Program Directors of local non-profits (14 responders)
Student Interest Clubs	Adult Facilitators, Students (Gender & Sexuality, Muslim Association, Black Union, Latin-X) (3 responders & 36 youth)
Social Services Human	Board Members, City Staff (9 responders)
Healthy Relationships Presentations	City Council, Mayor, Community, Teachers, School Counselors, students (15 responders & 180 youth)
Stress & Anxiety Awareness	Students (155 youth)
Mental Health Awareness	School Administration, Support Faculty, Teachers, Students (10 responders & 200 youth)
Middle School Mental Health	Teachers, students (4 responders & 300 youth)
Youth Development Teams	Students (21 youth)

Whole School Assembly on Mental Health	Administrators, counselors, students (86 responders & 1,786 youth) *Not counted b/c multiple duplicates
SBHC Teacher Info Packet	School Faculty (270 responders) *not counted b/c multiple duplicates
COST Meetings	Principals, Deans, Counselors, Teachers (24 responders) *not counted b/c duplicates

Demographics

Report disaggregate numbers served, number of potential responders engaged, and number of referrals for treatment and other services for the following categories:

Age Group

Children/Youth (0-15)	300
Transition Age Youth (16-25)	838
Adult (26-59)	113
Older Adult (60+)	
Declined to Answer	

Race

American Indian or Alaska Native	
Asian	269
Black or African American	78
Native Hawaiian or other Pacific Islander	62
White	290
Other	166
More than one race	114
Declined to Answer	272

Ethnicity (Cultural Heritage)

Hispanic or Latino as follows:	
Caribbean	
Central American	
Mexican/Mexican---American/Chicano	
Puerto Rican	
South American	
Other	
Declined to Answer	
Non---Hispanic or Non---Latino as follows:	
African	
Asian Indian/South Asian	
Cambodian	
Chinese	
Eastern European	
European	
Filipino	
Japanese	

Korean	
Middle Eastern	
Vietnamese	
Other	
More than one ethnicity	
Declined to Answer	1,251

Primary Languages

English	
Spanish	
Chinese Dialect	
Japanese	
Filipino Dialect	
Vietnamese	
Laotian	
Cambodian	
Sign ASL	
Other Non---English	
Korean	
Russian	
Polish	
German	
Italian	
Mien	
Hmong	
Turkish	
Hebrew	
French	
Cantonese	
Mandarin	
Portuguese	
Armenian	
Arabic	
Samoan	
Thai	
Farsi	
Other Sign	
Other Chinese Dialects	
Ilocano	
Declined to Answer	1,251

Sexual Orientation

Gay or Lesbian	13
Heterosexual or Straight	
Bisexual	
Questioning or unsure of sexual orientation	

Queer	
Another sexual orientation	
Decline to Answer	1,238

Disability

Yes	
Communication Domain:	
Difficulty Seeing	
Difficulty hearing, or having speech understood	
Other (specify)	
Mental Domain	
Physical/Mobility Domain	
Chronic Health Condition	
Other	
No	
Decline to Answer	1,251

Veteran Status

Yes	
No	1,138
Decline to Answer	113

Gender

Assigned sex at birth:	
Male	648
Female	603
Decline to Answer	
Current Gender Identity:	
Male	
Female	
Transgender	2
Gender queer	
Questioning or Unsure of Gender Identity	
Another Gender Identity	
Decline to Answer	1,249

As required for each Outreach for Increasing Recognition of Early Signs of Mental Illness Program:

Implementation Challenges:

Collecting demographic information continues to be a challenge as outreach efforts are made in large, public settings on school campus or in the community. Some of the demographic information is sensitive in nature and can be a deterrent to students freely engaging with staff at events.

Success:

Integrating into the Mental Health Matters class at one of the local high schools. The class is English Elective with a selection of books and literature that focus on mental illness. This year the School-Based Health Center connected with the teacher as we noticed a number of youth who access our mental health services have or plan to take the class. Staff facilitated two presentations in the class, one on warning signs of mental illness and another on how to be a mental health ally. The mental health ally presentation focused on how youth can support their peers managing a mental illness, as well as how to connect them to local mental health resources.

Lessons Learned:

This year our youth development team had identified stress as a major issue that was negatively impacting their peers and a major risk factor for mental illness. Staff began working on an outreach strategy and included the youth in the design. The youth were very helpful in providing suggestions about phrasing, timing, and materials. This led to a successful event that connected with 155 youth at just one high school. We saw the impact of youth voice and engagement not only for the youth who participated in the event, but for the youth involved in the planning. Moving forward, when appropriate, we plan to offer and empower youth to voice their ideas, suggestions, and critique.

Relevant Examples of Success/Impact:

Following the presentations in the Mental Health Matters class, a student from the class came to the School-Based Health Center to ask follow up questions about the various services offered. The student was introduced to the staff and conducted a brief intake. Through the intake, the student disclosed symptoms of a mental illness that was greatly impacting his life. The student began individual counseling with a therapist at the School-Based Health Center and has continued to receive services through the summer. The client has opened up to his family about his struggles and is now also receiving support at home.

Additional Information:

In this section please include the number of outreach contacts you estimate to provide in:
FY 17/18: N/A
FY 18/19: 1,400
FY 19/20: 1,600

Any changes you intend to make to your program over the next three fiscal years:
FY 17/18: N/A
FY 18/19: In the upcoming year, we plan to engage youth more frequently in the planning of our events in a strategic effort to ensure the messaging is culturally relevant at reaching our target audience.
FY 19/20: Exploring and identifying ways to engage middle school faculty and youth.

Outreach for Increasing Recognition of Early Signs of Mental Illness Program
PEI Data Report FY 17/18

As required for each Outreach for Increasing Recognition of Early Signs of Mental Illness Program:

MHSA program Number: **PEI 1F**

The Program Name: **Community-Based Mental Health Outreach & Consultation**

Program Description: EBAC's Fremont Healthy Start Program engages, encourages, and trains potential community responders, primarily family members of youth and children but also school staff and community members, about ways to recognize and respond to early signs of mental illness.

Total number of potential responders: 963

List type of setting(s) in which the potential responders were engaged and the type(s) of potential responders engaged in each setting:

Type of Setting(s) (ex: school)	**Type(s) of Potential Responders** (ex: principals, teachers, parents, nurses) Separate each type of responder with a
Family Resource Centers	Parents, Caregivers, general community members
Places of Worship	Clergy, congregation members
School	School staff, teachers, parents and caregivers

Demographics

Report disaggregate numbers served, number of potential responders engaged, and number of referrals for treatment and other services for the following categories:

Age Group

Children/Youth (0---15)	44
Transition Age Youth (16---25)	91
Adult (26---59)	557
Older Adult (60+)	271
Declined to Answer	

Race

American Indian or Alaska Native	12
Asian	432
Black or African American	10
Native Hawaiian or other Pacific Islander	3
White	283
Other	185
More than one race	0
Declined to Answer	38

Ethnicity (Cultural Heritage)

Hispanic or Latino as follows:	
Caribbean	
Central American	116
Mexican/Mexican---American/Chicano	192
Puerto Rican	
South American	1
Other	52
Declined to Answer	
Non---Hispanic or Non---Latino as follows:	
African	
Asian Indian/South Asian	57
Cambodian	
Chinese	218
Eastern European	
European	
Filipino	32
Japanese	
Korean	80
Middle Eastern	19
Vietnamese	12
Other	24
More than one ethnicity	
Declined to Answer	160

Primary Languages

English	213
Spanish	370
Chinese Dialect	
Japanese	
Filipino Dialect	
Vietnamese	
Laotian	
Cambodian	
Sign ASL	
Other Non-English	72
Korean	88
Russian	
Polish	
German	
Italian	
Mien	
Hmong	
Turkish	
Hebrew	
French	
Cantonese	74
Mandarin	117
Portuguese	
Armenian	
Arabic	
Samoan	
Thai	
Farsi	29
Other Sign	
Other Chinese Dialects	
Ilocano	
Declined to Answer	144

Sexual Orientation

Gay or Lesbian	2
Heterosexual or Straight	488
Bisexual	
Questioning or unsure of sexual orientation	
Queer	
Another sexual orientation	
Decline to Answer	473

Disability

Yes	133
Communication Domain:	
Difficulty Seeing	10
Difficulty hearing, or having speech understood	10
Other (specify)	
Mental Domain	10
Physical/Mobility Domain	13
Chronic Health Condition	8
Other	18
No	467
Decline to Answer	427

Veteran Status

Yes	
No	876
Decline to Answer	87

Gender

Assigned sex at birth:	
Male	344
Female	531
Decline to Answer	88
Current Gender Identity:	
Male	344
Female	531
Transgender	
Gender queer	
Questioning or Unsure of Gender Identity	
Another Gender Identity	
Decline to Answer	88

As required for each Outreach for Increasing Recognition of Early Signs of Mental Illness Program:

Implementation Challenges:

Families visiting EBAC's Fremont Healthy Start program for the first time often do not feel comfortable divulging private family information regarding mental health. Staff may have to see a new family multiple times to develop trust before the family begins sharing information. The program is successful in engaging families, but at times it is difficult to locate a therapist that speaks the appropriate language. Fremont Healthy Start staff generally refers these families to the Hume Center, but sometimes there is a waiting list. Staff also refers to Alameda County Behavioral Health Care Services' ACCESS Program, but a therapist is not always available in the language needed.

Success:

Staff report that what makes an encounter successful is when staff is able to relate to the client, which occurs regularly due to the staff's personal experience with issues such as immigration, divorce, child custody, etc. Being able to relate to a client's personal struggles makes the conversation easier and helps to develop and maintain trust. Many clients have personal or cultural stigmas associated with counseling, and these conversations about personal issues help clients become more open to accepting a referral to therapy.

Staff also report success in community member's following up with the program after a contact during an outreach event.

The Fremont Healthy Start program gained a new referral source, Alameda Alliance, during this quarter. Alameda Alliance will begin offering on-site education to families on Medi-Cal.

EBAC completed 88% (reached 963 outreach contacts out of 1,100) of contract goals. The program will be analyzing end-of-year results and demographics to further refine targeted outreach. Staff also will be reviewing mental health assessment and collateral materials.

Staff successfully implemented outcome measures for the Fremont Healthy Start program via questions from the Protective Factors Survey. Following are the results from a sampling of Fremont Healthy Start participants who completed a post service questionnaire:

- 89% either strongly or mostly agreed with the statement "If there is a crisis, I have others I can talk to." (pre-service result: 56%)
- 93% either strongly or mostly agreed with the statement "I know where to get help if I had trouble making ends meet." (pre-service result: 56%)
- 96% either strongly or mostly agreed with the statement "I have an idea of where to turn if my family needed food or housing." (pre-service result: 56%)

Staff has learned that having many strong partnerships is key to increasing access to mental health services. This year, the program began partnerships with Union City Family Center (Kid Zone) and Tri City Health Center.

Additionally, based on feedback from staff, the program is revising its tracking form to be more user friendly and easier to navigate. All Fremont Healthy Start staff will be trained on the new form once complete.

Because of EBAC staff's outreach, education efforts and enrollment of immigrants into health insurance plans, particularly Medi-Cal, EBAC has increased access to mental health services and raised awareness among many communities that mental health is a medically covered service.

Relevant Examples of Success/Impact:

A mother of two daughters ages 16 and 8, who were new arrivals to the United States, visited the Fremont Healthy Start program for assistance. During intake, a staff member performed a mental health assessment, but no significant challenges were revealed. Over the 10 months that the staff member assisted the mother and maintained contact with her, the mother began sharing that her husband and father of her children was emotionally and physically abusive and that she had some mild health issues. A most recent contact with the family revealed that the husband had stabbed their oldest daughter and police had been called. The mother knew little about mental health resources in the community, and the EBAC staff member made a referral to the Hume Center and other counseling resources for the mother and both daughters. The staff member also referred the family to Youth and Family Services and a youth summer camp, and continues to follow up with the family. This story illustrates how crucial it is to develop trust with clients to address their mental health issues and needs and ensure their safety.

Additional Information

In this section please include the number of outreach contacts you estimate to provide in:
FY 17/18: 1,100
FY 18/19: 1,500
FY 19/20: 1,500

Any changes you intend to make to your program over the next three fiscal years:

EBAC will seek funding to provide more intensive case management services to at-risk families.

Outreach for Increasing Recognition of Early Signs of Mental Illness Program
PEI Data Report FY 17/18

As required for each Outreach for Increasing Recognition of Early Signs of Mental Illness Program:

MHSA Program: **PEI 13**

Program Name: **Wellness, Recovery & Resiliency Services- Berkeley Drop-In Center**

Program Description:

A self-help community center offering housing advocacy, groups, support and other activities. Berkeley Drop In promotes freedom of choice, independent living and empowerment.

Total number of potential responders: 1,250

List type of setting(s) in which the potential responders were engaged and the type(s) of potential responders engaged in each setting:

Type of Setting(s) (ex: school)	**Type(s) of Potential Responders** (ex: principals, teachers, parents, nurses) Separate each type of responder with a comma.
On Site Homeless services	Consumers (TAY, Adults, Older adults, adults with minor children)
On site Housing services	Consumers (TAY, Adults, Older adults, adults with minor children)
On site AOD services	Consumers (TAY, Adults, Older adults, adults with minor children)
On site Groups	Consumers (TAY, Adults, Older adults, adults with minor children)
On site one on one peer counseling	Consumers (TAY, Adults, Older adults, adults with minor children)
On Site Homeless services	Consumers (TAY, Adults, Older adults, adults with minor children)
On site Housing services	Consumers (TAY, Adults, Older adults, adults with minor children)
On site AOD services	Consumers (TAY, Adults, Older adults, adults with minor children)

Demographics

Report disaggregate numbers served, number of potential responders engaged, and number of referrals for treatment and other services for the following categories:

Age Group

Children/Youth (0-- 15)	0
Transition Age Youth (16-- 25)	82
Adult (26-- 59)	839
Older Adult (60+)	648
Declined to Answer	943

Race

American Indian or Alaska Native	97
Asian	
Black or African American	1,372
Native Hawaiian or other Pacific Islander	46
White	173
Other	169
More than one race	181
Declined to Answer	474

Ethnicity (Cultural Heritage)

Hispanic or Latino as follows:	
Caribbean	42
Central American	22
Mexican/Mexican-- American/Chicano	70
Puerto Rican	31
South American	12
Other	217
Declined to Answer	1,373
Non-Hispanic or Non-Latino as follows:	
African	573
Asian Indian/South Asian	17
Cambodian	9
Chinese	20
Eastern European	
European	31
Filipino	9
Japanese	6
Korean	2
Middle Eastern	1
Vietnamese	3
Other	163
More than one ethnicity	123
Declined to Answer	1,085

Primary Languages

English	1,464
Spanish	10
Chinese Dialect	
Japanese	
Filipino Dialect	
Vietnamese	
Laotian	
Cambodian	
Sign ASL	
Other Non-English	
Korean	
Russian	
Polish	
German	
Italian	
Mien	
Hmong	
Turkish	
Hebrew	
French	
Cantonese	
Mandarin	
Portuguese	
Armenian	
Arabic	
Samoan	
Thai	
Farsi	
Other Sign	
Other Chinese Dialects	
Ilocano	

Sexual Orientation

Gay or Lesbian	724
Heterosexual or Straight	878
Bisexual	36
Questioning or unsure of sexual orientation	8
Queer	21
Another sexual orientation	83
Decline to Answer	762

Disability

Yes	
Communication Domain:	
Difficulty Seeing	265
Difficulty hearing, or having speech understood	132
Other (specify)	293
Mental Domain	620
Physical/Mobility Domain	354
Chronic Health Condition	204
Other	293
No	
Decline to Answer	436

Veteran Status

Yes	138
No	
Decline to Answer	

Gender

Assigned sex at birth:	
Male	
Female	
Decline to Answer	
Current Gender Identity:	
Male	1,311
Female	479
Transgender	10

Gender queer	11
Questioning or Unsure of Gender Identity	13
Another Gender Identity	26
Decline to Answer	662

As required for each Access and Linkage to Treatment Strategy:

Number of individuals with SMI referred to treatment: NA
Number of individuals followed through on referral & engaged in treatment: NA
Average duration of untreated mental illness: NA Standard Deviation: NA
Average time between referral and participation in treatment: NA Standard Deviation: NA

As required for each Improve Timely Access to Services for Underserved Populations Strategy:

Identify target population: individuals with mental health or substance abuse challenges in Alameda County
Number of referrals to a **Prevention** program: NA
Number of individuals followed through on referral & engaged in treatment: NA
Average time between referral and participation in treatment: NA Standard Deviation: NA
Number of referrals to an **Early Intervention** program: NA
Number of individuals followed through on referral & engaged in treatment: NA
Average time between referral and participation in treatment: NA Standard Deviation: NA

And/Or:

Number of referrals to **treatment beyond early onset:** NA
Number of individuals followed through on referral & engaged in treatment: NA
Average time between referral and participation in treatment: NA Standard Deviation: NA
Describe ways the County encouraged access to services and follow-through on referrals:

Outreach for Increasing Recognition of Early Signs of Mental Illness Program
PEI Data Report FY 17/18

As required for each Outreach for Increasing Recognition of Early Signs of Mental Illness Program:

MHSA Program: **PEI 13**

Program Name: **Wellness, Recovery & Resiliency Services- Best Now**

Program Description:

BEST NOW provides peer specialist training, supported internships, skill building seminars, and pre-employment workshops for job seekers, including document training to prepare consumers for employment.

Total number of potential responders: 50

List type of setting(s) in which the potential responders were engaged and the type(s) of potential responders engaged in each setting:

Type of Setting(s) (ex: school)	**Type(s) of Potential Responders** (ex: principals, teachers, parents, nurses) Separate each type of responder with a comma.
On-site Classroom training	Consumer: Adults, Older adults, TAY
Off- Site Workshops	Consumer: Adults, Older adults, TAY
On -site Workshops	Consumer: Adults, Older adults, TAY, community providers
Off- Site internship placement support	Consumer: Adults, Older adults, TAY, Community providers, and supervisors
Onsite Documentation training	Consumer: Adults, Older adults, TAY, community providers

Demographics

Report disaggregate numbers served, number of potential responders engaged, and number of referrals for treatment and other services for the following categories:

Age Group

Children/Youth (0-- 15)	0
Transition Age Youth (16-- 25)	4
Adult (26-- 59)	42
Older Adult (60+)	4
Declined to Answer	0

Race

American Indian or Alaska Native	0
Asian	
Black or African American	21
Native Hawaiian or other Pacific Islander	0
White	20
Other	9
More than one race	0
Declined to Answer	0

Ethnicity (Cultural Heritage)

Hispanic or Latino as follows:	
Caribbean	0
Central American	0
Mexican/Mexican-- American/Chicano	3
Puerto Rican	0
South American	0
Other	47
Declined to Answer	0
Non-Hispanic or Non-Latino as follows:	
African	12
Asian Indian/South Asian	0
Cambodian	0
Chinese	0
Eastern European	
European	24
Filipino	6
Japanese	0
Korean	0
Middle Eastern	0
Vietnamese	0
Other	3
More than one ethnicity	9
Declined to Answer	2

Primary Languages

English	50
Spanish	
Chinese Dialect	
Japanese	
Filipino Dialect	
Vietnamese	
Laotian	
Cambodian	
Sign ASL	
Other Non-English	
Korean	
Russian	
Polish	
German	
Italian	
Mien	
Hmong	
Turkish	
Hebrew	
French	
Cantonese	
Mandarin	
Portuguese	
Armenian	
Arabic	
Samoan	
Thai	
Farsi	
Other Sign	
Other Chinese Dialects	
Ilocano	

Sexual Orientation

Gay or Lesbian	0
Heterosexual or Straight	48
Bisexual	1
Questioning or unsure of sexual orientation	0
Queer	1
Another sexual orientation	0
Decline to Answer	0

Disability

Yes	
Communication Domain:	
Difficulty Seeing	18
Difficulty hearing, or having speech understood	6
Other (specify)	0
Mental Domain	24
Physical/Mobility Domain	1
Chronic Health Condition	1
Other	0
No	
Decline to Answer	0

Veteran Status

Yes	0
No	50
Decline to Answer	

Gender

Assigned sex at birth:	
Male	
Female	
Decline to Answer	
Current Gender Identity:	
Male	27
Female	14
Transgender	0
Gender queer	9

Questioning or Unsure of Gender Identity	0
Another Gender Identity	0
Decline to Answer	0

As required for each Access and Linkage to Treatment Strategy:
Number of individuals with SMI referred to treatment: **N/A**
Number of individuals followed through on referral & engaged in treatment: NA
Average duration of untreated mental illness: NA Standard Deviation: NA
Average time between referral and participation in treatment: NA Standard Deviation: NA

As required for each Improve Timely Access to Services for Underserved Populations Strategy:
Identify target population: Consumers, Adults, older adults, TAY
Number of referrals to a **Prevention** program: **N/A**
Number of individuals followed through on referral & engaged in treatment: NA
Average time between referral and participation in treatment: NA Standard Deviation: NA
Number of referrals to an **Early Intervention** program: NA
Number of individuals followed through on referral & engaged in treatment: NA
Average time between referral and participation in treatment: NA Standard Deviation: NA

And/Or:
Number of referrals to **treatment beyond early onset:** NA
Number of individuals followed through on referral & engaged in treatment: NA
Average time between referral and participation in treatment: NA Standard Deviation: NA
Describe ways the County encouraged access to services and follow through on referrals: NA

As required for each Outreach for Increasing Recognition of Early Signs of Mental Illness Program:

Implementation Challenges:

Many of our deliverables do not happen during July, August besides the workshops. During these months we are doing heavy recruitment for our training.

1. ***Deliverable: Contractor shall assist students completing the Peer Specialist Training to obtain an appropriate field placement and shall provide 180 hours of employment group supervision/oversight during the six-month internship period.***

- Challenges: From 25 students selected in our training in the beginning, only 15 people advanced into the internship phase. 4 students got a late start with the internship due to a delay in their background check. We provided 3 visits of dual supervision with each student and communicated with their supervisors through emails and phone calls. Providing 12 hours of supervision to each student is not realistic due to other demands of our training.
-

2. ***Deliverable:Contractor shall provide (2) six-week trainings using the curriculum, Documentation in Action, for 24 Peer Specialists who are currently working or interning in Behavioral Health and have some experience with case management and documentation.***

- Challenges: This deliverable has to be implemented by outsourcing and hiring a contractor. The two we have worked with in the past were not available and did not contact us back after several attempts. We were finally able to schedule the training but it was too late to implement it in our 16-17 fiscal year.

Outreach for Increasing Recognition of Early Signs of Mental Illness Program

PEI Data Report FY 17/18

As required for each Outreach for Increasing Recognition of Early Signs of Mental Illness Program:

MHSA Program: **PEI 13**

Program Name: **Wellness, Recovery & Resiliency Services- Reaching Across**

Program Description:

Reaching Across is a consumer-run self-help support center. It includes access to Wellness, Recovery Action Plan (WRAP) Groups, peer support groups, wellness and creative arts activities, computer classes and office skills training groups and off-site community integration events.

Total number of potential responders: 170

List type of setting(s) in which the potential responders were engaged and the type(s) of potential responders engaged in each setting:

Type of Setting(s) (ex: school)	**Type(s) of Potential Responders** (ex: principals, teachers, parents, nurses) Separate each type of responder with a comma.
On-site support groups	consumers (adult and older adult population)
On-site creative activities	consumers (adult and older adult population)
On-site physical health/wellness activities	consumers (adult and older adult population)
On-site employment support	consumers (adult and older adult population)
On-site peer counseling	consumers (adult and older adult population)
Phone peer counseling	consumers (adult and older adult population)
Off-site social outings	consumers (adult and older adult population)
Off-site physical health activities	consumers (adult and older adult population)
Off-site monthly picnic	family members and loved ones of consumers, consumers (adult and older adult population)
Off-site support group	consumers (adult and older adult population)

Demographics

Report disaggregate numbers served, number of potential responders engaged, and number of referrals for treatment and other services for the following categories:

Age Group

Children/Youth (0-- 15)	0
Transition Age Youth (16-- 25)	96
Adult (26-- 59)	62
Older Adult (60+)	
Declined to Answer	12

Race

American Indian or Alaska Native	54
Asian	
Black or African American	38
Native Hawaiian or other Pacific Islander	38
White	40
Other	
More than one race	80
Declined to Answer	2

Ethnicity (Cultural Heritage)

Hispanic or Latino as follows:	
Caribbean	0
Central American	0
Mexican/Mexican-- American/Chicano	50
Puerto Rican	0
South American	50
Other	70
Declined to Answer	
Non-- Hispanic or Non-- Latino as follows:	
African	38
Asian Indian/South Asian	
Cambodian	
Chinese	
Eastern European	40

European	
Filipino	
Japanese	
Korean	
Middle Eastern	
Vietnamese	
Other	10
More than one ethnicity	36
Declined to Answer	44

Primary Languages

English	131
Spanish	39
Chinese Dialect	
Japanese	
Filipino Dialect	
Vietnamese	
Laotian	
Cambodian	
Sign ASL	
Other Non--English	
Korean	
Russian	
Polish	
German	
Italian	
Mien	
Hmong	
Turkish	
Hebrew	
French	
Cantonese	
Mandarin	
Portuguese	
Armenian	

Arabic	
Samoan	
Thai	
Farsi	
Other Sign	
Other Chinese Dialects	
Ilocano	

Sexual Orientation

Gay or Lesbian	28
Heterosexual or Straight	80
Bisexual	36
Questioning or unsure of sexual orientation	0
Queer	28
Another sexual orientation	0
Decline to Answer	18

Disability

Yes	
Communication Domain:	
Difficulty Seeing	78
Difficulty hearing, or having speech understood	96
Other (specify)	
Mental Domain	
Physical/Mobility Domain	134
Chronic Health Condition	162
Other	0
No	
Decline to Answer	4

Veteran Status

Yes	62
No	108
Decline to Answer	

Gender

Assigned sex at birth:	
Male	
Female	
Decline to Answer	
Current Gender Identity:	
Male	100
Female	48
Transgender	0
Gender queer	22
Questioning or Unsure of Gender Identity	0
Another Gender Identity	0
Decline to Answer	0

As required for each Access and Linkage to Treatment Strategy:

Number of individuals with SMI referred to treatment: NA
List type(s) of treatment referred to: NA
Number of individuals followed through on referral & engaged in treatment: NA
Average duration of untreated mental illness: NA Standard Deviation: NA
Average time between referral and participation in treatment: NA Standard Deviation: NA

As required for each Improve Timely Access to Services for Underserved Populations Strategy:

Number of referrals to a **Prevention** program: NA
Number of individuals followed through on referral & engaged in treatment: NA
Average time between referral and participation in treatment: NA Standard Deviation: NA
Number of referrals to an **Early Intervention** program: NA
Number of individuals followed through on referral & engaged in treatment: NA
Average time between referral and participation in treatment: NA Standard Deviation: NA

And/Or:

Number of referrals to **treatment beyond early onset:** NA
Number of individuals followed through on referral & engaged in treatment: NA
Average time between referral and participation in treatment: NA Standard Deviation: NA
Describe ways the County encouraged access to services and follow- through on referrals: NA

Outreach for Increasing Recognition of Early Signs of Mental Illness Program
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As required for each Outreach for Increasing Recognition of Early Signs of Mental Illness Program:

MHSA Program: **PEI 13**

Program Name: **Wellness, Recovery & Resiliency Services- Reach Out**

Program Description: Reach out offers a volunteer visitor program to mental health and board and care facilities to present to residents about available community services.

Total number of potential responders: 310

List type of setting(s) in which the potential responders were engaged and the type(s) of potential responders engaged in each setting:

Type of Setting(s) (ex: school)	**Type(s) of Potential Responders** (ex: principals, teachers, parents, nurses) Separate each type of responder with a comma.
locked psychiatric facilities	mental health clients
board and care facilities	mental health clients

Demographics

Report disaggregate numbers served, number of potential responders engaged, and number of referrals for treatment and other services for the following categories:

Age Group

Children/Youth (0-- 15)	0
Transition Age Youth (16-- 25)	32
Adult (26-- 59)	194
Older Adult (60+)	61
Declined to Answer	23

Race

American Indian or Alaska Native	6
Asian	
Black or African American	110
Native Hawaiian or other Pacific Islander	7
White	105
Other	43

More than one race	28
Declined to Answer	11

Ethnicity (Cultural Heritage)

Hispanic or Latino as follows:	
Caribbean	2
Central American	13
Mexican/Mexican-- American/Chicano	16
Puerto Rican	10
South American	2
Other	51
Declined to Answer	216
Non-Hispanic or Non-Latino as follows:	
African	100
Asian Indian/South Asian	1
Cambodian	0
Chinese	7
Eastern European	
European	54
Filipino	10
Japanese	2
Korean	2
Middle Eastern	1
Vietnamese	0
Other	48
More than one ethnicity	32
Declined to Answer	53

Primary Languages

English	231
Spanish	12
Chinese Dialect	
Japanese	
Filipino Dialect	
Vietnamese	

Laotian	
Cambodian	
Sign ASL	
Other Non-English	67
Korean	
Russian	
Polish	
German	
Italian	
Mien	
Hmong	
Turkish	
Hebrew	
French	
Cantonese	
Mandarin	
Portuguese	
Armenian	
Arabic	
Samoan	
Thai	
Farsi	
Other Sign	
Other Chinese Dialects	
Ilocano	
Declined to Answer	

Sexual Orientation

Gay or Lesbian	4
Heterosexual or Straight	195
Bisexual	8
Questioning or unsure of sexual orientation	1
Queer	2
Another sexual orientation	14
Decline to Answer	86

Disability

Yes	285
Communication Domain:	
Difficulty Seeing	9
Difficulty hearing, or having speech understood	7
Other (specify)	
Mental Domain	216
Physical/Mobility Domain	26
Chronic Health Condition	12
Other	15
No	
Decline to Answer	25

Veteran Status

Yes	12
No	
Decline to Answer	198

Gender

Assigned sex at birth:	
Male	
Female	
Decline to Answer	
Current Gender Identity:	
Male	152
Female	129
Transgender	0
Genderqueer	2
Questioning or Unsure of Gender Identity	2
Another Gender Identity	0
Decline to Answer	25

As required for each Access and Linkage to Treatment Strategy:

Number of individuals with SMI referred to treatment: NA
Number of individuals followed through on referral & engaged in treatment: NA
Average duration of untreated mental illness: NA Standard Deviation: NA
Average time between referral and participation in treatment: NA Standard Deviation: NA

As required for each Improve Timely Access to Services for Underserved Populations Strategy:

Identify target population: Board and Care residents
Number of referrals to a **Prevention** program: NA
Number of individuals followed through on referral & engaged in treatment: NA
Average time between referral and participation in treatment: NA Standard Deviation: NA
Number of referrals to an **Early Intervention** program: NA
Number of individuals followed through on referral & engaged in treatment: NA
Average time between referral and participation in treatment: NA Standard Deviation: NA

And/Or:

Number of referrals to **treatment beyond early onset:** NA
Number of individuals followed through on referral & engaged in treatment: NA
Average time between referral and participation in treatment: NA Standard Deviation: NA

Describe ways the County encouraged access to services and follow--through on referrals: NA

Outreach for Increasing Recognition of Early Signs of Mental Illness Program
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As required for each Outreach for Increasing Recognition of Early Signs of Mental Illness Program:

MHSA Program: **PEI 13**

Program Name: **Wellness, Recovery & Resiliency Services- Tenant Support**

Program Description:

Program provides the following Housing Core Tasks: Outreach and Engagement, Partnership Development, Triage Assessment, Linkages. Additionally, program provides Wellness, Recovery Action Planning (WRAP) Groups, housing application completion assistance and assistance with completing the Everyone Home Loan process.

Total number of potential responders: 350

List type of setting(s) in which the potential responders were engaged and the type(s) of potential responders engaged in each setting:

Type of Setting(s) (ex: school)	**Type(s) of Potential Responders** (ex: principals, teachers, parents, nurses) Separate each type of responder with a comma.
On-site discussion group	consumers (adults and older adults)
On-site housing support	consumers (adults, older adults, women with dependent children)
On-site social activities	consumers (adults and older adults)
On-site transportation services	consumers (adults, older adults, women with dependent children)

Demographics

Report disaggregate numbers served, number of potential responders engaged, and number of referrals for treatment and other services for the following categories:

Age Group

Children/Youth (0-- 15)	0
Transition Age Youth (16-- 25)	6
Adult (26-- 59)	112
Older Adult (60+)	139
Declined to Answer	93

Race

American Indian or Alaska Native	47
Asian	
Black or African American	20
Native Hawaiian or other Pacific Islander	2
White	38
Other	154
More than one race	7
Declined to Answer	82

Ethnicity (Cultural Heritage)

Hispanic or Latino as follows:	
Caribbean	0
Central American	0
Mexican/Mexican-- American/Chicano	42
Puerto Rican	0
South American	0
Other	10
Declined to Answer	298
Non-Hispanic or Non-Latino as follows:	
African	142
Asian Indian/South Asian	12
Cambodian	1
Chinese	0
Eastern European	
European	4
Filipino	4
Japanese	1
Korean	1
Middle Eastern	11
Vietnamese	0
Other	162
More than one ethnicity	12
Declined to Answer	249

Primary Languages

English	341
Spanish	4
Chinese Dialect	
Japanese	
Filipino Dialect	
Vietnamese	
Laotian	
Cambodian	
Sign ASL	
Other Non-English	5
Korean	
Russian	
Polish	
German	
Italian	
Mien	
Hmong	
Turkish	
Hebrew	
French	
Cantonese	
Mandarin	
Portuguese	
Armenian	
Arabic	
Samoan	
Thai	
Farsi	
Other Sign	
Other Chinese Dialects	
Ilocano	
Declined to Answer	

Sexual Orientation

Gay or Lesbian	64
Heterosexual or Straight	205
Bisexual	22
Questioning or unsure of sexual orientation	1
Queer	8
Another sexual orientation	50
Decline to Answer	103

Disability

Yes	
Communication Domain:	
Difficulty Seeing	115
Difficulty hearing, or having speech understood	80
Other (specify)	
Mental Domain	258
Physical/Mobility Domain	173
Chronic Health Condition	52
Other	69
No	
Decline to Answer	174

Veteran Status

Yes	103
No	247
Decline to Answer	

Gender

Assigned sex at birth:	
Male	
Female	
Decline to Answer	
Current Gender Identity:	
Male	94
Female	139
Transgender	1

Gender queer	0
Questioning or Unsure of Gender Identity	0
Another Gender Identity	50
Decline to Answer	65

As required for each Access and Linkage to Treatment Strategy:

Number of individuals with SMI referred to treatment: NA
Number of individuals followed through on referral & engaged in treatment: NA
Average duration of untreated mental illness: NA Standard Deviation: NA
Average time between referral and participation in treatment: NA Standard Deviation: NA

As required for each Improve Timely Access to Services for Underserved Populations Strategy:

Identify target population: individuals seeking, transitioning to and maintaining housing
Number of referrals to a **Prevention** program: NA
Number of individuals followed through on referral & engaged in treatment: NA
Average time between referral and participation in treatment: NA Standard Deviation: NA
Number of referrals to an **Early Intervention** program: NA
Number of individuals followed through on referral & engaged in treatment: NA
Average time between referral and participation in treatment: NA Standard Deviation: NA

And/Or:

Number of referrals to **treatment beyond early onset:** NA
Number of individuals followed through on referral & engaged in treatment: NA
Average time between referral and participation in treatment: NA Standard Deviation: NA

Describe ways the County encouraged access to services and follow through on referrals: NA

As required for each Outreach for Increasing Recognition of Early Signs of Mental Illness Program:

Implementation Challenges:

Lack of affordable housing/ Landlords require 3x the rent

Successes:

At least 1 more Everyone Home Application was approved for May 2018. No one applied for the month of June.

Lessons Learned:

Looking outside Alameda County Is helpful when looking for affordable housing

Relevant Examples:

Continue supportive services by networking with other agencies - ie. Trust Clinic. Lifelong Medical, La Clinica.

Prevention Program
PEI Data Report FY 17/18

As required for each Prevention Program:

MHSA program Number: **PEI 13**

Program Name: **Wellness, Recovery & Resiliency Services- Wellness Recovery Action Planning (WRAP)**

Program Description: PEERS continues to hold four ongoing WRAP groups in English and Spanish at various Alameda County locations, including one for transition-age youth. We also reach approximately 300 consumers and family members with WRAP orientations, and promote consumer leadership by training and supporting consumers to become WRAP facilitators.

Number of **unduplicated** individuals served in the preceding fiscal year (FY 16/17): 697
Number of individual family members (this number will be included in your total above): N/A

Demographics

Report disaggregate numbers served, number of potential responders engaged (for agencies conducting outreach), and number of referrals for treatment and other services for the following categories:

Age Group (Unduplicated)

Children/Youth (0---15)	2
Transition Age Youth (16---25)	54
Adult (26---59)	519
Older Adult (60+)	120
Declined to Answer	2

Race (Unduplicated)

American Indian or Alaska Native	9
Asian	40
Black or African American	220
Native Hawaiian or other Pacific Islander	2
White	122
Other	0
More than one race	22
Declined to Answer	283

Ethnicity (Cultural Heritage)

Hispanic or Latino as follows:	
Caribbean	0
Central American	0
Mexican/Mexican-American/Chicano	0
Puerto Rican	0
South American	0
Other	0
Declined to Answer	96
Non-Hispanic or Non-Latino as follows:	
African	2
Asian Indian/South Asian	0
Cambodian	0
Chinese	0
Eastern European	0
European	0
Filipino	0
Japanese	0
Korean	0
Middle Eastern	0
Vietnamese	0
Other	0
More than one ethnicity	26
Declined to Answer	584

Primary Languages

English	662
Spanish	35
Chinese Dialect	0
Japanese	0
Filipino Dialect	0
Vietnamese	0
Laotian	0
Cambodian	0
Sign ASL	0
Other Non-English	0
Korean	0
Russian	0
Polish	0
German	0

Sexual Orientation

Gay or Lesbian	Not yet tracked. In 2018-19, PEERS will survey participants over a one-month period to generate estimates.
Heterosexual or Straight	
Bisexual	
Questioning or unsure of sexual orientation	
Queer	
Another sexual orientation	
Decline to Answer	

Disability

Yes	
Communication Domain:	
Difficulty Seeing	Not yet tracked. In 2018-19, PEERS will survey participants over a one-month period to generate estimates.
Difficulty hearing, or having speech understood	
Other (specify)	
Mental Domain	
Physical/Mobility Domain	
Chronic Health Condition	
Other	
No	
Decline to Answer	

Veteran Status

Yes	Not yet tracked. In 2018-19, PEERS will survey participants
No	
Decline to Answer	

Gender

Assigned sex at birth:	
Male	Not yet tracked. In 2018-19, PEERS will survey participants over a one-month
Female	
Decline to Answer	
Current Gender Identity:	
Male	298
Female	264
Transgender	2
Gender queer	0
Questioning or Unsure of Gender Identity	0
Another Gender Identity	0
Decline to Answer	133

Access and to Treatment Strategy (Required):

Number of individuals who followed through on referral & engaged in treatment: 0
Average duration of untreated mental illness: NA Standard Deviation: NA
Average time between referral and participation in treatment: NA Standard Deviation: NA

Improving Timely Access to Services for Underserved Populations *Strategy (*Required):

Target population: Mental health consumers, primarily people of color
Number of referrals to a **Prevention** program: 697
Number of referrals to an **Early Intervention** program: NA
Number of individuals followed through on referral & engaged in early intervention treatment services: NA
Average time between referral and participation in treatment: NA Standard Deviation: NA

And/Or

Number of referrals to **BHCS treatment system (beyond early onset):** NA
Number of individuals followed through on referral & engaged in treatment: NA
Average time between referral and participation in treatment: NA Standard Deviation: NA

As required for each Prevention Program:

Implementation Challenges:

At the TRUST Health Center we offered WRAP to the center's clients: adults with disabling conditions and histories of homelessness, who also participate in Alameda County's General Assistance Program. After the first session, only one to two participants attended.

Success:

We started a partnership with OUSD to provide training to teachers. The plan is to train students over the next couple of years so that they can run their own (peer-led) WRAP groups. All the ongoing PEERS WRAP groups maintained attendance consistently higher than the minimum average of five participants per session as specified in our deliverables.

Lessons Learned:

The TRUST Clinic was a one cycle group (one 10-week session). From this, we learned that groups are more successful when offered on an ongoing basis. In 18-19 fiscal year, we will provide an ongoing WRAP group at this location and expect to see better outcomes.

Relevant Examples of Success/Impact:

Personal sharing is a key aspect of WRAP that benefits participants and this benefit was reflected in the group evaluations. When asked what they learned about mental health, one participant responded "*diferentes ideas, consejos y experiencias que se comparten en el grupo*," (different ideas, advice and experiences that the group shares). This feedback truly validates that PEERS is implementing WRAP according to the program's values and ethics which state that we are not teachers, but merely facilitators of the participants identifying their own definitions of wellness and strategies for achieving and maintaining that wellness.

Additional Information

In this section please include the number of clients and/or contacts you estimate to serve in:

FY 18/19: reach a minimum of 750 participants reached through WRAP
FY 19/20: reach a minimum of 800 participants reached through WRAP
FY 20/21: reach a minimum of 900 participants reached through WRAP

Any changes you intend to make to your program over the next three fiscal years:

Over the next three years we plan to increase outreach efforts to reach communities that we are not currently serving. In FY 18/19 we will create a three-year outreach strategy that includes an increase in participants reached each year. Our goals are:

- Partner with OUSD to provide support to High School and Junior High students through WRAP and our ECC campaign.
- Partner with older Adult communities specifically targeting isolated older adults in board and care homes and senior centers.
- Partner with Foster care and Criminal Justice systems to outreach to these communities
- Partner with organizations that support Immigrant communities to educate on mental health and wellness. We plan to train bilingual people in this community on WRAP so that we can hold groups in other languages.

Outreach for Increasing Recognition of Early Signs of Mental Illness Program
PEI Data Report FY 17/18

As required for each Outreach for Increasing Recognition of Early Signs of Mental Illness Program:

MHSA program Number: **PEI 19**

The Program Name: **Older Adults Peer Support- Peer Coaching for Older Adult LGBT Community (City of Fremont)**

Program Description: The program provides supportive services to support the LGBT older adult community. The program provides outreach and prevention services to enhance existing programming in the older adult population. The program aims to reduce social isolation by providing services that encourage and support positive social support networks and relationships that reduces the risk of prolonged suffering with peers, increase self confidence among target population, increase access to needed community resources. The program offers 1: 1 time with trained LGBT Peer Coach, Support Groups and Educational Resources.

Total number of potential responders: 7

List type of setting(s) in which the potential responders were engaged and the type(s) of potential responders engaged in each setting:

Type of Setting(s) (ex: school)	**Type(s) of Potential Responders** (ex: principals, teachers, parents, nurses) Separate each type of
City of Fremont- Aging and Family services:	The program enrolled 3 clients this last quarter. Two clients are currently receiving services from our MSSP case management program.
San Jose State University and Cal East Bay university(school)	The program outreached to these universities and provided information about our LGBT program. Discussed potential referrals to the program.
City of Fremont Senior Peer Counseling Program	Program presentation to the new Senior Peer Counseling Program Coordinator. Discussed possible service collaboration and referrals.
City of Fremont- Senior Commissioners	Program presentation to the City of Fremont – Senior Commissioners.

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Demographics

Report disaggregate numbers served, number of potential responders engaged, and number of referrals for treatment and other services for the following categories:

Age Group

Children/Youth (0---15)	
Transition Age Youth (16---25)	
Adult (26---59)	
Older Adult (60+)	4
Declined to Answer	3

Race/Ethnicity

American Indian or Alaska Native	
Asian	
Black or African American	
Native Hawaiian or other Pacific Islander	
White	4
Other	
More than one race	
Declined to Answer	3
Hispanic or Latino as follows:	
Caribbean	
Central American	
Mexican/Mexican---American/Chicano	
Puerto Rican	
South American	
Other	
Declined to Answer	
Non---Hispanic or Non---Latino as follows:	
European	4
Filipino	
Declined to Answer	3

Primary Languages

English	4
Spanish	
Chinese Dialect	
Japanese	
Filipino Dialect	
Vietnamese	
Laotian	
Cambodian	
Sign ASL	
Other Non-English	
Decline to Answer	3

Sexual Orientation

Gay or Lesbian	3
Heterosexual or Straight	1
Bisexual	
Questioning or unsure of sexual orientation	
Queer	
Another sexual orientation	
Decline to Answer	3

Disability

Yes	4
Communication Domain:	
Difficulty Seeing	
Difficulty hearing, or having speech understood	
Other (specify)	
Mental Domain	4
Physical/Mobility Domain	4
Chronic Health Condition	4
Other	
No	
Decline to Answer	

Veteran Status

Yes	
No	4
Decline to Answer	3

Gender

Assigned sex at birth:	
Male	1
Female	3
Decline to Answer	3
Current Gender Identity:	
Male	2
Female	2
Transgender	
Genderqueer	
Questioning or Unsure of Gender Identity	
Another Gender Identity	
Decline to Answer	3

As required for each Access and Linkage to Treatment Strategy:

Number of individuals with SMI referred to treatment: 4

List type(s) of treatment referred to:

Clients were referred to Recovery and Resiliency Program to receive additional mental health services to further their stability and functioning. Clients were provided a trained senior peer coach who supports client in developing an action plan in the areas of community engagement, advocacy, and opportunities for a group outing to decrease isolation.

Number of individuals followed through on referral & engaged in treatment: 4

As required for each Improve Timely Access to Services for Underserved Populations Strategy:

Identify target population: Older Adults LGBT individuals
Number of referrals to a **Prevention** program: 4
Number of individuals followed through on referral & engaged in treatment: 4

Average time between referral and participation in treatment: 1 week Standard Deviation: NA
Number of referrals to an **Early Intervention** program: 0
Number of individuals followed through on referral & engaged in treatment: 0

Average time between referral and participation in treatment: NA Standard Deviation: NA

And/Or

Number of referrals to **treatment beyond early onset:** 0
Number of individuals followed through on referral & engaged in treatment: 4
Average time between referral and participation in treatment: 1 week Standard Deviation: NA

Describe ways the Agency encouraged access to services and follow-through on referrals:

- This program expands and supports county's mission to provided LGBT population easy access to needed services.
- This program utilizes specific strategies that are non-stigmatizing and non-discriminatory to facilitate treatment engagement and access to services.
- The program created a welcoming environment by posting LGBT flag and displaying LGBT community resources so clients can access services from other service providers.

As required for each Outreach for Increasing Recognition of Early Signs of Mental Illness Program:

Implementation Challenges:

- Difficulty engaging clients to the program due to fear of re-experiencing traumatic and painful experiences they had in the past.
- Stigma and rejecting behavior from their family, friends and their community keeps them isolated and feeling of not belonging to their community.
- To be successful in program implementation, the program needs to collaborate with the community and integrate services with other service providers.
- Finding knowledgeable and culturally competent LGBT health providers.

Successes:

- There are a number of people in the LGBT community who verbalized interest in learning more about the program, inquiring about volunteer work in the program and hopefully assisting the program to spread the word to the LGBT community.
- The program will utilize appropriate social media (Facebook) to post program information and flyers.

Lessons Learned:

- Isolation and the feeling of "not belonging" are still salient in the LGBTQ community. Being aware of this dilemma, we need to keep in mind the core values of the MHSA in implementing a successful program and sustaining it.
- Integrate service experience for clients and families.
- Lack of places clients can go and feel safe and supported.

Additional Information

Per county contract, the program will conduct public outreach, education and engagement in addition to establishing collaboration with community based agencies and /or advocacy organization.

The program goal is to provide services to 9 participants and seven must identify as LGBT.

Outreach for Increasing Recognition of Early Signs of Mental Illness Program
PEI Data Report FY 17/18

As required for each Outreach for Increasing Recognition of Early Signs of Mental Illness Program:

MHSA program Number: **PEI 20B**

The Program Name: **Culturally Responsive PEI Programs for the African American Community (Speakers Bureau) Black Men Speak, Inc**.

Program Description: Black Men Speak, Inc. is an inspirational speaker's bureau that aims to end the trauma, discrimination and stigma associated with mental health and substance abuse challenges.

Total number of potential responders: 178

List type of setting(s) in which the potential responders were engaged and the type(s) of potential responders engaged in each setting:

Type of Setting(s) (ex: school)	**Type(s) of Potential Responders** (ex: principals, teachers, parents, nurses) Separate each type of responder with a
Rehab Center	Consumers, counselors, doctors, program directors, families, case managers
Wellness Center	Client representative, consumers, counselors, employment services reps, case managers
Religious Organization	families, pastors, consumers,
Re-Entry Programs	Parents, families, consumers, case managers,
Clean Living Facility	Case managers, consumers,
Annual Festival	Anyone within the general public.
Annual Conference	Consumer run organizations, consumers, vendors,

Demographics

Report disaggregate numbers served, number of potential responders engaged, and number of referrals for treatment and other services for the following categories **(*Demographic information not available):**

Age Group

Children/Youth (0---15)	
Transition Age Youth (16---25)	
Adult (26---59)	
Older Adult (60+)	
Declined to Answer	

Race

American Indian or Alaska Native	0%
Asian	6%
Black or African American	33%
Native Hawaiian or other Pacific Islander	
White	20%
Other	8%
More than one race	4%
Declined to Answer	18%

Ethnicity (Cultural Heritage)

Hispanic or Latino as follows:	
Caribbean	
Central American	
Mexican/Mexican---American/Chicano	
Puerto Rican	
South American	
Other	
Declined to Answer	
Non---Hispanic or Non---Latino as follows:	
African	
Asian Indian/South Asian	
Cambodian	
Chinese	
Eastern European	
European	
Filipino	
Japanese	
Korean	
Middle Eastern	
Vietnamese	
Other	
More than one ethnicity	
Declined to Answer	

Primary Languages

English	100%
Spanish	
Chinese Dialect	
Japanese	
Filipino Dialect	
Vietnamese	
Laotian	
Cambodian	
Sign ASL	
Other Non---English	
Korean	
Russian	
Polish	
German	
Italian	
Mien	
Hmong	
Turkish	
Hebrew	
French	
Cantonese	
Mandarin	
Portuguese	
Armenian	
Arabic	
Samoan	
Thai	
Farsi	
Other Sign	
Other Chinese Dialects	
Ilocano	
Decline to Answer	

Sexual Orientation

Gay or Lesbian	
Heterosexual or Straight	
Bisexual	
Questioning or unsure of sexual orientation	
Queer	
Another sexual orientation	
Decline to Answer	

Disability

Yes	
Communication Domain:	
Difficulty Seeing	
Difficulty hearing, or having speech understood	
Other (specify)	
Mental Domain	
Physical/Mobility Domain	
Chronic Health Condition	
Other	
No	
Decline to Answer	

Veteran Status

Yes	
No	
Decline to Answer	

Gender

Assigned sex at birth:	
Male	
Female	
Decline to Answer	
Current Gender Identity:	
Male	
Female	
Transgender	
Genderqueer	
Questioning or Unsure of Gender Identity	
Another Gender Identity	
Decline to Answer	

Describe ways your program encouraged access to services and follow-through on referrals:

We currently encourage access through handouts at our events. However, we are in the process of developing a system of contacts and services that would better service our target population.

As required for each Outreach for Increasing Recognition of Early Signs of Mental Illness Program:

Implementation Challenges:

Our program started late as it took more time than anticipated to recruit a staff member to manage the data/evaluation. We do feel good about the foundation that has been set, but will be collaborating more with PEERS and BHCS the coming fiscal year to further streamline processes.

Success:

BMS recruited 11 new members through word-of-mouth and outreach efforts. We conducted the following activities to support recruitment and community engagement:

- We participated in 9 outreach events such as We Move For Health and POCC related events.
- We held a Father's Day event on June 8th at East Bay Church of Religious Sciences to provide a space for men to be celebrated and to share about BMS program.

BMS created a website and has a social media presence. We found this to be helpful when conducting outreach to organizations for speaking engagements.

Lessons Learned:

Keep up to date information on additional services and resources available to individuals at our events.

Relevant Examples of Success/Impact:

From Our Speakers

"BMS has given me a greater sense of higher purpose, wisdom from peers, and brotherhood." – Patrick

"I was given a chance to speak at Cronin House, where I used to live, and it allowed me to share my story of overcoming challenges with the current residents." – Norman

From Our Audience

A participant from Allen Temple expressed learning that **"recovery is real"**

A participant at ConRep expressed that the presentation gave him **"hope"**

Additional Information:

In this section please include the number of outreach contacts you estimate to provide in:

FY 18/19: Develop a targeted outreach strategy, contact list and referral follow-through plan and continue to build relationships throughout the community with individuals and agencies. Develop a women's group for the same target area. Monitor process improvement to develop strategic changes for the FY 19/20

FY 19/20: Increase Outreach contacts for this year 250, Increase our outreach area to include surrounding cities within Alameda County. Recruit and increase bureau memberships to twenty-five (25) speakers. Create outreach teams. Develop and monitor strategies to increase our impact and influence throughout Alameda County. Develop strategic marketing plan.

FY 20/21: Increase Outreach contacts for this year 300. Increase and maintain speakers that represent the audience we want to educate and impact. Continue to increase outreach activities. Continue developing and monitoring process improvements. Create a comprehensive training for speakers. Continue to impact targeted audience.

Any changes you intend to make to your program over the next three fiscal years:

FY 18/19: We are developing a women's group.

FY 19/20: We would like to offer WRAP groups and peer support at our facility.

FY 20/21: We would like to create a comprehensive training and certificate program for speakers.

Outreach for Increasing Recognition of Early Signs of Mental Illness Program
PEI Data Report FY 17/18

As required for each Outreach for Increasing Recognition of Early Signs of Mental Illness Program:

MHSA program Number: **PEI 20C**

The Program Name: **Culturally Responsive PEI Programs for the African American Community (Family Supports)**

Program Description: Free quarterly workshops offers help for family members who seek support and care for those who are living with mental illness and/or are addicted to drugs or alcohol. The program provides opportunities to talk with mental health and substance use professionals and share stories with peer families.

Total number of potential responders: Approximately 179

List type of setting(s) in which the potential responders were engaged and the type(s) of potential responders engaged in each setting:

Type of Setting(s) (ex: school)	**Type(s) of Potential Responders** (ex: principals, teachers, parents, nurses) Separate each type of responder with a comma.
Community Mental Health Organizations	clinicians, clinical interns, clinical trainees, administrative staff
Community-Based Organizations	direct services staff, administrative staff; program participants
Health Care Organizations	direct services staff, administrative staff; program participants
County Agency	direct services staff, administrative staff

Demographics

Report disaggregate numbers served, number of potential responders engaged, and number of referrals for treatment and other services for the following categories:

Age Group

Children/Youth (0---15)	0
Transition Age Youth (16---25)	0
Adult (26---59)	0
Older Adult (60+)	0
Declined to Answer	179

Race

American Indian or Alaska Native	0
Asian	0
Black or African American	0
Native Hawaiian or other Pacific Islander	0
White	0
Other	0
More than one race	0
Declined to Answer	179
Hispanic or Latino as follows:	
Caribbean	0
Central American	0
Mexican/Mexican---American/Chicano	0
Puerto Rican	0
South American	0
Other	0
Declined to Answer	0
Non---Hispanic or Non---Latino as follows:	
African	0
Asian Indian/South Asian	0
Cambodian	0
Chinese	0
Eastern European	0
European	0
Filipino	0
Japanese	0
Korean	0
Middle Eastern	0
Vietnamese	0
Other	0
More than one ethnicity	0
Declined to Answer	179

Primary Languages

English	0
Spanish	0
Chinese Dialect	0
Japanese	0
Filipino Dialect	0
Vietnamese	0
Laotian	0
Cambodian	0
Sign ASL	0
Other Non-English	0
Korean	0
Russian	0
Polish	0
German	0
Italian	0
Mien	0
Hmong	0
Turkish	0
Hebrew	0
French	0
Cantonese	0
Mandarin	0
Portuguese	0
Armenian	0
Arabic	0
Samoan	0
Thai	0
Farsi	0
Other Sign	0
Other Chinese Dialects	0
Ilocano	0
Declined to Answer	179

Sexual Orientation

Gay or Lesbian	0
Heterosexual or Straight	0
Bisexual	0
Questioning or unsure of sexual orientation	0
Queer	0
Another sexual orientation	0
Decline to Answer	179

Disability Status

Yes	0
Communication Domain:	
Difficulty Seeing	0
Difficulty hearing, or having speech understood	0
Other (specify)	0
Mental Domain	0
Physical/Mobility Domain	0
Chronic Health Condition	0
Other	0
No	0
Decline to Answer	179

Veteran Status

Yes	0
No	0
Decline to Answer	179

Gender

Assigned sex at birth:	
Male	0
Female	0
Decline to Answer	0
Current Gender Identity:	
Male	0
Female	0
Transgender	0
Gender queer	0
Questioning or Unsure of Gender Identity	0
Another Gender Identity	0
Decline to Answer	179

As required for each Access and Linkage to Treatment Strategy:

Number of individuals with SMI referred to treatment: N/A
Number of individuals followed through on referral & engaged in treatment: N/A
Average duration of untreated mental illness: N/A Standard Deviation: N/A
Average time between referral and participation in treatment: N/A Standard Deviation: N/A

As required for each Improve Timely Access to Services for Underserved Populations Strategy:

Target population: N/A
Number of referrals to a **Prevention** program: N/A
Number of individuals followed through on referral & engaged in prevention services: N/A
Average time between referral and participation in prevention services: N/A Standard Deviation: N/A
Number of referrals to an **Early Intervention** program: N/A
Number of individuals followed through on referral & engaged in early intervention: N/A
Average time between referral and participation in early intervention: N/A Standard Deviation: N/A

And/Or

Number of referrals to **treatment (beyond early onset):** N/A
Number of individuals followed through on referral & engaged in treatment: N/A
Average time between referral and participation in treatment: N/A Standard Deviation: N/A

Implementation Challenges:

We don't have mechanisms to gather information about what kinds of referrals are requested and given, especially at our resource tables. We also don't have a method to survey participants about potential changes in/additional to our programming, such as the desire for a longer day or a conference style expansion of topics.

Successes:

Because the program is focused on an underserved population group, participants often learn about new services and resources. Family members with lived experience have shared, "When mental illness or substance abuse hit our loved ones, we did not know where to turn. In these workshops, we're actually able to talk with the managing psychiatrist for Alameda County Behavioral Health Care Services and get answers. It made a huge difference."

Relevant Examples of Success:

We recognize that every population group needs to acknowledge and talk about mental illness and substance abuse, especially with members of the same group. We also know that groups may have justified concerns about poor treatment at the hands of law enforcement, for example. Our main presenter on substance abuse describes his own journey from heroin and cocaine addition to recovery in a way that audience members can see that addiction is an illness that can be treated and transcended.

Prevention Program
PEI Data Report FY 17/18

As required for each Prevention Program:

MHSA program Number: **PEI 22**

Program Name: **LGBT Support Services- Older & Out, Older Adult LGBT Peer Supports**

Program Description: Older & Out provides drop-in therapy groups for LGBTQ older adults, age 60+ in north, central and east Alameda County. Groups are free, run for 90 minutes, welcome new members at any time, and refreshments are provided. They are facilitated by clinical interns, assisted by local LGBTQ age 60+ older adults.

Number of **unduplicated** individuals served in the preceding fiscal year (FY 17/18): 92
Number of individual family members (this number will be included in your total above): NA

Demographics

Report disaggregate numbers served, number of potential responders engaged (for agencies conducting outreach), and number of referrals for treatment and other services for the following categories:

Age Group (Unduplicated)

Children/Youth (0---15)	
Transition Age Youth (16---25)	
Adult (26---59)	4
Older Adult (60+)	88
Declined to Answer	

Race (Unduplicated)

American Indian or Alaska Native	4
Asian	2
Black or African American	10
Native Hawaiian or other Pacific Islander	0
White	62
Other	
More than one race	2
Declined to Answer	12

Ethnicity (Cultural Heritage)

Hispanic or Latino as follows:	
Caribbean	
Central American	
Mexican/Mexican---American/Chicano	
Puerto Rican	
South American	
Other	
Declined to Answer	7
Non---Hispanic or Non---Latino as follows:	
African	
Asian Indian/South Asian	
Cambodian	
Chinese	
Eastern European	
European	
Filipino	
Japanese	
Korean	
Middle Eastern	
Vietnamese	
Other	
More than one ethnicity	
Declined to Answer	85

Primary Languages

English	90
Spanish	2
Chinese Dialect	
Japanese	
Filipino Dialect	
Vietnamese	
Laotian	
Cambodian	
Sign ASL	
Other Non---English	

Sexual Orientation

Gay or Lesbian	77
Heterosexual or Straight	2
Bisexual	11
Questioning or unsure of sexual orientation	
Queer	1
Another sexual orientation	1
Decline to Answer	

Disability

Yes	32
Communication Domain:	
Difficulty Seeing	3
Difficulty hearing, or having speech understood	6
Other (specify)	
Mental Domain	5
Physical/Mobility Domain	9
Chronic Health Condition	9
Other	
No	60
Decline to Answer	

Veteran Status

Yes	
No	
Decline to Answer	92

Gender

Assigned sex at birth:	
Male	55
Female	33
Decline to Answer	4
Current Gender Identity:	
Male	53
Female	36
Transgender	
Gender queer	3
Questioning or Unsure of Gender Identity	
Another Gender Identity	
Decline to Answer	

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

This section is optional. Please complete if your program conducts outreach activities in relation to your program.

Total number of potential responders (outreach audience): 285

List type of setting(s) in which the potential responders were engaged and the type(s) of potential responders engaged in each setting:

Type of Setting(s) (ex: school, community center)	**Type(s) of Potential Responders** (ex: principals, teachers, parents, nurses, peers) Separate each type of responder with a comma.
Senior Center	Seniors, Home care providers, Therapists, Administrators, Community members, Family
LGBTQ Center	LGBTQ Community members, especially LGBTQ Seniors/Older adults/Peers
Social Services Center	Social workers, Case managers, Medical providers, Administrators, Community Members
Senior Ct.r Gay Day Event	LGBTQ Seniors, Advocates, Community Members, Family, Peers

Access and Linkage to Treatment Strategy (Required):

Number of individuals with SMI or SED referred to BHCS treatment system (includes county and CBO providers): NA

List type(s) of treatment referred to:

There is not a record that any group members requested any BHCS services. No referrals for BHCS services were recorded by the group therapists. This indicates a change we need to make at the front end - to record during intake if someone has SMI so that we can better track them regarding referrals and treatment needs. Generally we have seen that our group members are already well connected to services, don't reveal their SMI status. We have had one potential group member who declined to complete the initial intake paperwork due to being closeted and two others who appeared to be struggling with SMI symptoms that prevented them from participating and they refused referrals.

Number of individuals who followed through on referral & engaged in treatment: UNK
Average duration of untreated mental illness: UNK Standard Deviation: UNK
Average time between referral and participation in treatment: UNK Standard Deviation: UNK

Improving Timely Access to Services for Underserved Populations *Strategy (*Required):

Target population: LGBTQ Older Adults
Number of referrals to a **Prevention** program: None
Number of referrals to an **Early Intervention** program: None
Number of individuals followed through on referral & engaged in early intervention treatment services: None

Average time between referral and participation in treatment: NA Standard Deviation: NA

And/Or

Number of referrals to **BHCS treatment system (beyond early onset):** None
Number of individuals followed through on referral & engaged in treatment: None
Average time between referral and participation in treatment: NA Standard Deviation: NA

As required for each Prevention Program:

Implementation Challenges:

The two large challenges Older & Out works to overcome is stigma and spreading the word about our new program. Older adults grew up in a time when other sexual and gender identities were highly stigmatized, and this can create barriers, especially because Older & Out services are drop-in groups. Many older adults, if they came out of the closet, sometimes go back in because of safety, and are isolated, which means it is very hard for us or other providers to reach them with information about our program.

Success:

Given the challenges, reaching almost 100 older adults in Older & Out's first year has been a huge success. Our first survey of program participants showed that despite our uncommon drop-in therapy group model, 75% of participants report that the program meets their needs.

Lessons Learned:

We've learned many lessons this past year. While we don't regret starting a group in Livermore, it never attracted a critical mass of people, and we ended it in June. We've also learned that having two therapists, or one therapist and one Pacific Center staff member at our Oakland and North Berkeley meeting locations is important for a variety of reasons.

Relevant Examples of Success/Impact:

" I've been coming to the Older and Out peer group for almost six months now, and it has helped change my life in ways I couldn't have imagined before… I wound up in the mental hospital the first time when I was sixteen years old… It was hard at first to tell my story, especially about my mental hospital stays and suicide attempts, but these were all fellow gays and lesbians I was talking to and they were so accepting. Just like me, I've seen others in the group open up and share their stories, a lot of times for the first time, and sometimes with more than a few tears."

This edited excerpt from a longer letter sent by a member of one of our Older & Out groups demonstrates how stigma can cause lifelong barriers for older adults, but that when we reach and get older adults participating, it can be ***life changing.***

In this section please include the number of clients and/or contacts you estimate to serve in:
FY 18/19: 95 – 120 unduplicated
FY 19/20: 95 – 130 unduplicated

Additional Information

Any changes you intend to make to your program over the next three fiscal years:

We are anticipating expansion with more groups being offered in more locations. We plan to target our outreach to reach more people of color, women and/or transgender potential members. We are open to developing peer groups in locations that are not open to therapy groups.

Outreach for Increasing Recognition of Early Signs of Mental Illness Program
PEI Data Report FY 17/18

As required for each Outreach for Increasing Recognition of Early Signs of Mental Illness Program:

MHSA program Number: **PEI 22**

The Program Name: **LGBT Support Services- Technical Assistance (TA) Program/Pacific Center**

Program Description: The TA Program conducted by the Pacific Center provides Cultural Humility trainings to other Bay Area non-profits. These trainings enable both clinical and non-clinical providers to serve the LGBTQ+ community in a way that is more culturally responsive. Pre-training site visits and surveys help tailor the trainings to the needs of each agency they work with. Pacific Center also provides as needed grief counseling to community members, including first responders, following unexpected traumatic local events.

Total number of potential responders: 23 organizations/facilitated workshops; approximately 650 attendees

List type of setting(s) in which the potential responders were engaged and the type(s) of potential responders engaged in each setting:

Type of Setting(s) (ex: school)	**Type(s) of Potential Responders** (ex: principals, teachers, parents, nurses) Separate each type of responder with a comma.
Community Mental Health Organizations	clinicians, clinical interns, clinical trainees, administrative staff
Senior Centers	direct services staff, administrative staff
Jails	direct services staff, administrative staff
County Agency	direct services staff, administrative staff
Youth Services Organizations	direct services staff, administrative staff

Demographics

Report disaggregate numbers served, number of potential responders engaged, and number of referrals for treatment and other services for the following categories:

Age Group

Children/Youth (0---15)	0
Transition Age Youth (16---25)	0
Adult (26---59)	0
Older Adult (60+)	0
Declined to Answer	650

Race

American Indian or Alaska Native	0
Asian	0
Black or African American	0
Native Hawaiian or other Pacific Islander	0
White	0
Other	0
More than one race	0
Declined to Answer	650
Hispanic or Latino as follows:	
Caribbean	0
Central American	0
Mexican/Mexican---American/Chicano	0
Puerto Rican	0
South American	0
Other	0
Declined to Answer	0
Non---Hispanic or Non---Latino as follows:	
African	0
Asian Indian/South Asian	0
Cambodian	0
Chinese	0
Eastern European	0
European	0
Filipino	0
Japanese	0
Korean	0
Middle Eastern	0
Vietnamese	0
Other	0
More than one ethnicity	0
Declined to Answer	650

Primary Languages

Declined to Answer	650

Sexual Orientation

Gay or Lesbian	0
Heterosexual or Straight	0
Bisexual	0
Questioning or unsure of sexual orientation	0
Queer	0
Another sexual orientation	0
Decline to Answer	650

Disability Status

Yes	0
Communication Domain:	
Difficulty Seeing	0
Difficulty hearing, or having speech understood	0
Other (specify)	0
Mental Domain	0
Physical/Mobility Domain	0
Chronic Health Condition	0
Other	0
No	0
Decline to Answer	650

Veteran Status

Yes	0
No	0
Decline to Answer	650

Gender

Assigned sex at birth:	
Male	0
Female	0
Decline to Answer	0
Current Gender Identity:	
Male	0
Female	0
Transgender	0
Genderqueer	0
Questioning or Unsure of Gender Identity	0
Another Gender Identity	0
Decline to Answer	650

As required for each Access and Linkage to Treatment Strategy:

Number of individuals with SMI referred to treatment: N/A

Number of individuals followed through on referral & engaged in treatment: N/A

Average duration of untreated mental illness: N/A Standard Deviation: N/A
Average time between referral and participation in treatment: N/A Standard Deviation: N/A

As required for each Improve Timely Access to Services for Underserved Populations Strategy:

Target population: N/A
Number of referrals to a **Prevention** program: N/A
Number of individuals followed through on referral & engaged in prevention services: N/A
Average time between referral and participation in prevention services: N/A Standard Deviation: N/A

Number of referrals to an **Early Intervention** program: N/A
Number of individuals followed through on referral & engaged in early intervention: N/A
Average time between referral and participation in early intervention: N/A Standard Deviation: N/A

And/Or

Number of referrals to **treatment (beyond early onset):** N/A
Number of individuals followed through on referral & engaged in treatment: N/A
Average time between referral and participation in treatment: N/A Standard Deviation: N/A

Additional Information

Any changes you intend to make to your program over the next three fiscal years:

We are adjusting our evaluation forms so that we are able to collect demographic data. We are also offering scaffolded trainings to agencies so that learning can be deepened, adjusted and more targeted for each organization/group.

Access and Linkage to Treatment Program
PEI Data Report FY 17/18

As required for each Access and Linkage to Treatment Program:

MHSA Program Number: **PEI 1B**

Program Name: **School-Based Mental Health Access & Linkage in Elementary, Middle & High Schools**

Program Description: This program is a school-based mental health consultation and access and linkage program that provides services in 16 of 18 Alameda County school districts. It is a partnership between Behavioral Health Care Services (BHCS) and the Center for Healthy Schools and Communities (CHSC). Coordination of Services Teams (COST) help refer and connect students to prevention and early intervention or treatment services.

Number of individuals with SMI referred to treatment: 7,513

List type(s) of treatment referred to:

Youth are primarily referred to outpatient school-based mental health treatment programs, but are also referred to community-based outpatient treatment programs. Treatment options may include individual therapy, group therapy, a combination of both individual and group therapy, parent/family therapy, and/or case management.

Number of individuals followed through on referral & engaged in treatment: 6,461 (86%)
Average duration of untreated mental illness: Data N/A Standard Deviation: N/A

Average time between referral and participation in treatment: 67% were connected to treatment less than 1 month after the initial referral; 27% were connected within 1-2 months after referral Standard Deviation: N/A

Demographics

Report disaggregate numbers served, number of referrals for treatment and other services for the following categories:

Approximately 13,879 youth were referred to Coordination of Services Teams (COST) at their schools during the 2017-2018 school year. Of those, 7,513 (or 54%) were referred to treatment services, and 2,826 (or 20%) were referred to prevention services. Demographic data is for all youth reached through COST.

Age Group (n=13,257)

Children/Youth (0-15)	71%
Transition Age Youth (16-25)	18%
Adult (26-59)	
Older Adult (60+)	
Declined to Answer	11%

Race (Unduplicated)

American Indian or Alaska Native	1%
Asian	9%
Black or African American	22%
Native Hawaiian or other Pacific Islander	1%
White (includes Hispanic and White Non-Hispanic)	43% (please note, 10% are White Non-Hispanic and 33% are Hispanic)
Other	3%
More than one race	4%
Declined to Answer	20%

Ethnicity (Cultural Heritage)

Hispanic or Latino as follows: (n=4,400)	
Caribbean	
Central American	7
Mexican/Mexican-American/Chicano	208
Puerto Rican	0
South American	0
Other	175
Declined to Answer	4,010
Non-Hispanic or Non-Latino as follows: (n=8,984)	
African	155
Asian Indian/South Asian	66
Cambodian	5
Chinese	100
Eastern European	0
European	163
Filipino	178
Japanese	4
Korean	7
Middle Eastern	18
Vietnamese	26
Other	355
More than one ethnicity	76
Declined to Answer	
	6,365

Primary Languages (n=12,146)

English	46% (n=5,645)
Spanish	27% (n=3,287)
Chinese Dialect	2% (n=186)
Japanese	
Filipino Dialect	0.5% (n=57)
Vietnamese	
Laotian	
Cambodian	
Sign ASL	
Other Non-English	4% (n=476)
Korean	0.03% (n=4)
Russian	
Polish	
German	
Italian	
Mien	
Hmong	
Turkish	
Hebrew	
French	
Cantonese	
Mandarin	
Portuguese	
Armenian	
Arabic	1% (n=146)
Samoan	
Thai	
Farsi	0.3% (n=36)
Other Sign	
Other Chinese Dialects	
Ilocano	
Missing or Declined to Answer	19% (n=2,310)

Sexual Orientation

Gay or Lesbian	
Heterosexual or Straight	
Bisexual	
Questioning or unsure of sexual orientation	
Queer	
Another sexual orientation	
Decline to Answer	7,513

Disability Status

Yes	
Communication Domain:	
Difficulty Seeing	
Difficulty hearing, or having speech understood	
Other (specify)	
Mental Domain	
Physical/Mobility Domain	
Chronic Health Condition	
Other	
No	
Decline to Answer	7,513

Veteran Status

Yes	
No	
Decline to Answer	7,513

Gender

Assigned sex at birth:	
Male	N/A
Female	N/A
Decline to Answer	N/A
Current Gender Identity: (n=13,343)	
Male	47% (n=6,275)
Female	38% (n=5,033)
Transgender	0.1% (n=13)
Genderqueer	0% (n=0)
Questioning or Unsure of Gender Identity	0.1% (n=19)
Another Gender Identity	0% (n=0)
Decline to Answer	15% (n=2,004)

As required for each Improve Timely Access to Services for Underserved Populations *Strategy*:

Target population: School-age youth
Number of referrals to a **Prevention** program: 2,826

Number of referrals to an **Early Intervention** program: NA
Number of individuals followed through on referral & engaged in early intervention services: NA
Average time between referral and participation in early intervention: NA Standard Deviation: NA

And/Or Treatment Program

Number of referrals to **treatment beyond early onset:** 7,513

Number of individuals followed through on referral & engaged in treatment: 86%
Average time between referral and participation in treatment: 67% were connected to treatment less than 1 month after the initial referral; 27% were connected within 1-2 months after referral
Standard Deviation: N/A

Describe ways your program encouraged access to services and follow-through on referrals:

The COST strategy relies on interpersonal networks and consistent family engagement to ensure youth and/or their caregivers connect to treatment. Teams engage the student and/or family prior to issuing a formal referral as they have found that this approach increases the likelihood that a student or family member will be willing to engage in and connect with treatment. As such, members of COST teams strive to connect with students and their families prior to formally making a referral to facilitate trust between students, families, and COST. COST teams have two clear priorities in making a treatment referral: 1) recommend treatment services that are the best fit for the student's needs, and are culturally competent, and 2) to assign a staff member who has a positive relationship with the student and/or family to serve as the liaison and navigator for accessing and connecting to treatment services. This staff member will meet with the family and student to explain the treatment referral, and support them in connecting to that service, whether it is on-site (i.e. at school) or off-site (i.e. at a community-based provider). In either case, it is technically the provider's responsibility, rather than the COST team's, to follow up after a formal referral is issued. However, because on-site services are much more closely connected to the COST team than off-site services, COST teams can collaborate with on-site services in outreach efforts to students and families to ensure that they follow-through on referrals. These strategies have led to a high connection rate, with 86% of students with referrals successfully connected to treatment.

As required for each Access and Linkage to Treatment Program

Implementation Challenges:

In many of the school districts served through this program, COST has become a key priority in supporting students with behavioral health needs, however, there are some schools or districts that are still in the emerging/growth phase of adopting COST as a regular and necessary component of the infrastructure of student services, supports, and positive school climate investments. Some challenges to implementing COST include:

- Ensuring that teachers (especially new teachers) are aware of COST, and know how and when it is appropriate to refer a student to COST. Specifically, encouraging teachers or school staff to refer students to COST proactively, instead of in reaction to a serious incident or concern.
- School district budget cuts may mean disinvestment in COST.
- Turnover in District or School Site leadership means needing to reengage district or school leadership in the importance of COST implementation.
- Lack of time for teacher professional development.

Success:

COST is now being implemented in 236 schools (out of a total of 299) in the 16 school districts where it operates. 79% of all schools have a functioning COST team. Six school districts now have COST in 100% of their schools; another 5 school districts have COST in a majority of their schools. Health and Wellness Consultants hired by the Center for Healthy Schools and Communities provide training and capacity building services to teachers, school leadership, and other staff on how to implement COST and how/when to refer students. In a survey of youth participants (n=194), 98% reported that they agreed or strongly agreed with the statement "I am satisfied with the services I received", and 99% agreed that their counselor treated them with respect.

Lessons Learned

Consistent engagement, buy-in, and support from school site leadership and district administration is important to ensuring fidelity to the COST model, and the type of financial and resource investment that is needed. Turnover in district and school leadership can lead to pauses or delays in COST implementation.

At the student level, there is a need to increase the number of culturally competent services and formats that are available to all students, especially newcomer immigrant students and students who may have arrived in this country unaccompanied by parents/guardians.

Relevant Examples of Impact/Success

Case studies of students supported through COST:

- *At a school in Fremont Unified:* A student at the high school was referred to COST because she was failing several classes and her friends and teacher were worried about her because they had heard rumors of abusive behavior in her relationship. Several people on the COST team tackled this case together and we were able to move the student into Art Academy, a class that she finds meaningful and motivating. We also had a teacher and counselor checking in with her frequently. It was a long road but eventually the student agreed to receive counseling from SAVE, one of our COST team's partner that provides support for those affected by domestic violence. Our Student Resource Officer was also involved and spoke with the boyfriend of the student to ensure that he was aware what abuse was and that it was not tolerated and had consequences.
- *New Haven Unified School District*: An elementary school student was referred to COST in the 3rd grade for multiple suspensions and disciplinary issues as well as low academic functioning. "Jerry" was given a thorough evaluation, a 504 plan, an IEP as well as mental health support. By the 4th grade Jerry's academics and behavior were improving and teachers were accommodating to Jerry's academic needs according to his 504 and IEP. Jerry received daily check-in's which were organized through COST as well as individual therapy. Jerry's suspensions were also declining. By the 5th grade, Jerry suspensions were non-existent and his grades improved dramatically. Jerry was also put in a 5th grade transition class to prepare him for middle school through COST. Through COST Jerry has received many resources that have helped academically and assisted him in learning coping skills, communication skills and social skill strategies which resulted in increased academic functioning and achievement.

Additional Information

In this section please include the number of clients and/or contacts you estimate to serve in:
FY 18/19: 8,000
FY 19/20: 8,500

Any changes you intend to make to your program over the next two fiscal years:

Programs and services are being expanded to serve newcomer youth and unaccompanied immigrant youth who are attending schools throughout the County.

Prevention Program
PEI Data Report FY17/18

As required for each Prevention Program:

MHSA program Number: **PEI 15**

Program Name: **Asian Health Services – Asian ACCESS: Access & Linkage to Treatment Programs**

Program Description: Asian ACCESS Program operates a designated Intake and Referral line, screens and evaluates for medical necessity and determines appropriate service levels for community members requesting mental health services. ACCESS provides short-term crisis stabilization outpatient

Number of **unduplicated** individuals served in the preceding fiscal year (FY 17/18): 424
Number of individual family members (this number will be included in your total above): NA

**** Qualifying Statement from Program Manager / AHS: Below Demographic data is based on the 424 unduplicated clients tracked in the BHCS Contact Tracking Database (Intake Database). Please be aware of the following features of the Intake Database: 1) The available stock reports on intake client's age group, ethnicity, language, and other attributes are based on services/contacts but not unique number/individual of intake clients; 2) the demographic data could not be captured for those intake clients who refused to provide names and whose unique client records were not created. With the limitation, the following demographic data is derived from the cautious extrapolation of the available statistical data from the Intake Database. ****

Demographics

Report disaggregate numbers served, number of potential responders engaged (for agencies conducting outreach), and number of referrals for treatment and other services for the following categories:

Age Group (Unduplicated)

Children/Youth (0--15)	61
Transition Age Youth (16--25)	73
Adult (26---59)	223
Older Adult (60+)	67
Declined to Answer	

Race (Unduplicated)

American Indian or Alaska Native	
Asian	406
Black or African American	7
Native Hawaiian or other Pacific Islander	
White	5
Other	6
More than one race	
Declined to Answer	1

Ethnicity (Cultural Heritage)

Hispanic or Latino as follows:	
Caribbean	
Central American	
Mexican/Mexican---American/Chicano	2
Puerto Rican	
South American	
Other	
Declined to Answer	
Non-Hispanic or Non-Latino as follows:	
African	7
Asian Indian/South Asian	
Cambodian	18
Chinese	291
Eastern European	
European	5
Filipino	15
Japanese	5
Korean	7
Middle Eastern	
Vietnamese	55
Other	18
More than one ethnicity	
Declined to Answer	1

Primary Languages

English	219
Spanish	
Chinese Dialect	1
Japanese	2
Filipino Dialect	3
Vietnamese	21
Laotian	1
Cambodian	12
Sign ASL	
Other Non---English	
Korean	1
Russian	
Polish	
German	
Italian	
Mien	1
Hmong	
Turkish	

Hebrew	
French	
Cantonese	133
Mandarin	28
Portuguese	
Armenian	
Arabic	
Samoan	
Thai	
Farsi	
Other Sign	
Other Chinese Dialects	
Ilocano	
Burmese (not on the original list)	2
Declined to Answer	

Sexual Orientation

Gay or Lesbian	
Heterosexual or Straight	
Bisexual	
Questioning or unsure of sexual orientation	
Queer	
Another sexual orientation	
Decline to Answer	424

Disability

Yes	
Communication Domain:	
Difficulty Seeing	
Difficulty hearing, or having speech understood	
Other (specify)	
Mental Domain	
Physical/Mobility Domain	
Chronic Health Condition	
Other	
No	
Decline to Answer	424

Veteran Status

Yes	
No	
Decline to Answer	424

Gender

Assigned sex at birth:	
Male	199
Female	225
Decline to Answer	
Current Gender Identity:	
Male	199
Female	224
Transgender	1
Genderqueer	
Questioning or Unsure of Gender Identity	
Another Gender Identity	
Decline to Answer	

Number of individuals with SMI or SED referred to BHCS treatment system (includes county and CBO providers): _____

List type(s) of treatment referred to:

- Language Acute Crisis Care & Evaluation for System-wide Services (Language ACCESS) Program such as Asian ACCESS Program; La Clinica's ACCESS Program;
- Adult Level 1 Service Team Program
- Adult Outpatient Therapy Program
- Children's Level 1 Program; Children's Hospital
- Early Childhood Program
- Asian Central County Children & Youth Services Program
- Medication Only Clinic (e.g. Pathway to Wellness)
- Integrated Behavioral Health in Primary Care Setting
- Sausal Creek Urgent Medication Clinic
- Mobile Crisis Team for home-based crisis evaluation
- Psychiatric Emergency Hospital (e.g. John George Psychiatric Pavilion, Willow Rock)
- In-Home Outreach Team

Number of individuals who followed through on referral & engaged in treatment: 120 (per available info for treatment case opening)
Average duration of untreated mental illness: unable to calculate at this time Standard Deviation: NA
Average time between referral and participation in treatment: 27.1 days (for tx case opening within 90 days); Standard Deviation: 18.7(for tx case opening with 90 days)

**** The duration above is calculated from the date of referral via phone/drop in/fax/mail to our Asian Access Intake Team. From the date of the confirmation of medical necessity and the corresponding tx assignment requests, almost all tx case openings were done for AHS internal treatment programs within 2 weeks. For external tx assignment requests, the tx case openings could not be tracked.*

Improving Timely Access to Services for Underserved Populations Strategy (Required):

Target population: Alameda County residents who are experiencing or are at risk of developing serious mental health issues; at least 75% of clients served are from API groups, from all age groups and geographic regions of Alameda County. Services are provided in API languages including but not limited to Burmese, Cantonese, Khmer, Korean, Japanese, Mandarin, Mien, Tagalog and Vietnamese.

Number of referrals to a **Prevention** program: 14
Number of referrals to an **Early Intervention** program: 14
Number of individuals followed through on referral & engaged in early intervention treatment services: 14
Average time between referral and participation in treatment: 40.6 days (for case opening within 90 days); Standard Deviation: 26.9 (for case opening within 90 days)

**** The duration above is calculated from the date of referral via phone/drop in/fax/mail to our Asian Access Intake Team.*

And/Or:

Number of referrals to **BHCS treatment system (beyond early onset):** 113
Number of individuals followed through on referral & engaged in treatment: 106 (per available info for case opening)
Average time between referral and participation in treatment: 25.7 days (for case opening within 90 days); Standard Deviation: 17.2 (for case opening within 90 days)

**** The duration above is calculated from the date of referral via phone/drop in/fax/mail to our Asian Access Intake Team. From the date of the confirmation of medical necessity and the corresponding tx assignment requests, almost all tx case openings were done for AHS internal treatment programs within 2 weeks. For external tx assignment requests, the tx case openings could not be tracked.*

As required for each Prevention Program:

Implementation Challenges:

In FY17-18, Asian ACCESS Program was able to assemble a team of 5 bilingual, license-track clinicians (FTE w/ part-time responsibilities on Intake & Referral duties). They were all new graduates but demonstrated capabilities to develop screening/assessment skills and incorporate knowledge about intake operation procedures, County's guidelines/programs, and referral resources. Limited resource allocation and the volume of intake/referral activities also restricted the time/effort for client engagement.

Success:

- Answered inquiries from 424 intake clients with more than 1800 services/contacts; connected with appropriate level of services and/or obtaining related info. Among these clients, 255 clients were engaged/screened (106 referrals to internal treatment programs, 14 referrals to internal Prevention program, 18 referrals to external treatment programs, 15 referrals to MH services by primary health care) and connected to appropriate level of services.
- Continuous review and enhancement of the Intake Process workflow to expedite screening, case assignment, case opening, and referrals. (Face to face safety planning session within 2 business days for intake clients with S/I and H/I but not meeting criteria for 5150 initiation; Collaboration with two leading community health centers for API clients for two-way referrals.)
- Addressed emergency suicidal assessment, homicidal assessment, and mental health related life stressors above and beyond our allocated Intake resources.
- Conducted pre-treatment home-based and hospital-based engagement services with clients in order to address shame/stigma, promote help seeking, and links to appropriate treatment services.

Lessons Learned:

- Owing to the clientele's shame and stigma around mental health issues and lack of knowledge about psychiatric services, a good number of API clients struggled with S/I, H/I and severe psychiatric symptoms when they were finally referred to seek services. It led to difficulties about client engagement and the immediate arrangement of psychiatric services with the limited/allocated resources.
- Owing to inadequate bilingual and culturally responsive mental health providers, it is always a challenge to refer out mild-moderate clients of Asian language/culture.

Relevant Examples of Success/Impact:

- Immediate phone-based crisis Intervention was provided, including developing safety plan, and diverting intake clients from psychiatric hospitalization. While clients were waiting for treatment assignments and case opening, a dual process was executed to conduct face to face safety planning sessions within 2 business days when it was warranted.
- Educated and supported family members on how to support and monitor client's psychiatric conditions. Also provided family members crisis resources.
- For clients who struggled with moderate-severe psychiatric symptoms but were not engaged in appropriate treatments, referrals were made to BHCS IHOT and BHCS STEPS and appropriate collaboration on engagements were made in order to address the corresponding barriers for clients and resource limitation amongst service teams.
- Conducted weekly conference calls for intake referral review with AHS IBH/Care Coordinator and periodical intake referral review/follow-up with San Antonio Neighborhood Health Center IBH/Care Coordinator to address clients' shame/stigma and language/cultural needs, and enhance the rate of referral follow-through.

Additional Information:

In this section please include the number of clients and/or contacts you estimate to serve in:
FY 18/19: 500 clients / 2130 contacts
FY 19/20: 550 clients / 2340 contacts
FY 20/21: 600 clients / 2550 contacts

Any changes you intend to make to your program over the next three fiscal years:

API population continues to struggle with shame/stigma around mental health and lack of knowledge about psychiatric services. With the exploration of possible increase in staff resource, we would like to revisit our process for the following: 1) Offer more psycho-education events and classes to the population according to their help seeking patterns, time availability, and cultural settings; 2) Conduct more timely pre-treatment home-based and hospital-based engagement visits and enhance collaboration with other BHCS outreach teams like IHOT, AOT, STEPS, etc.; 3) Provide pre-treatment case management to address intake client's life stressors in order to enhance client engagement through the experience of concrete help and stress alleviation.

Prevention Program
PEI Data Report FY 17/18

As required for each Prevention Program:

MHSA program Number: **PEI 16**

Program Name: **Acute Crisis Care and Evaluation for System-Wide Services (ACCESS) for Latino Population**

Program Description:

The ACCESS program offers entry into ACHBCS system of care with a focus on clients in need of Spanish language capacity. Adults and children with linguistic and culturally based need that are members of Spanish-speaking community are able to obtain screening, evaluation of medical necessity and referral to treatment. La Clínica offers crisis stabilization services to adults with high acuity mental health needs in order to reduce utilization of higher levels of care. La Clinica also provides services that increase functioning and coping skills; increase client's understanding of their mental illness and responsibility for monitoring/managing their treatment and recovery; increase and access to mental health services for underserved Latino communities in Alameda County.

Number of **unduplicated** individuals served in the preceding fiscal year (FY 17/18): 506

Number of individual family members (this number will be included in your total above): Unable to calculate at this time.

Demographics

Report disaggregate numbers served, number of potential responders engaged (for agencies conducting outreach), and number of referrals for treatment and other services for the following categories:

Age Group (Unduplicated)

Children/Youth (0--15)	148
Transition Age Youth (16--25)	87
Adult (26---59)	251
Older Adult (60+)	20
Declined to Answer	0

Race (Unduplicated)

American Indian or Alaska Native	
Asian	1
Black or African American	3
Native Hawaiian or other Pacific Islander	
White	6
Other	495

Ethnicity (Cultural Heritage)

Hispanic or Latino as follows:	
Caribbean	
Central American	81
Mexican/Mexican---American/Chicano	397
Puerto Rican	
South American	18
Other	
Declined to Answer	
Non---Hispanic or Non---Latino as follows:	
African	
Asian Indian/South Asian	
Cambodian	
Chinese	
Eastern European	
European	
Filipino	
Japanese	
Korean	
Middle Eastern	
Vietnamese	
Other	
More than one ethnicity	
Declined to Answer	10

Primary Languages

English	24
Spanish	481
Chinese Dialect	
Japanese	
Filipino Dialect	
Vietnamese	
Laotian	
Cambodian	
Sign ASL	
Other Non---English	1
Korean	
Russian	
Polish	
German	
Italian	
Mien	
Hmong	

Turkish	
Hebrew	
French	
Cantonese	
Mandarin	
Portuguese	
Armenian	
Arabic	
Samoan	
Thai	
Farsi	
Other Sign	
Other Chinese Dialects	
Ilocano	

Sexual Orientation

Gay or Lesbian	
Heterosexual or Straight	415
Bisexual	
Questioning or unsure of sexual orientation	
Queer	
Another sexual orientation	
Decline to Answer	91

Disability

Yes	
Communication Domain:	
Difficulty Seeing	
Difficulty hearing, or having speech understood	
Other (specify)	
Mental Domain	
Physical/Mobility Domain	1
Chronic Health Condition	
Other	
No	505
Decline to Answer	

Veteran Status

Yes	
No	440
Decline to Answer	65

Gender

Assigned sex at birth:	
Male	200
Female	306
Decline to Answer	
Current Gender Identity:	
Male	200
Female	306
Transgender	
Genderqueer	
Questioning or Unsure of Gender Identity	
Another Gender Identity	
Decline to Answer	

Access and Linkage to Treatment Strategy (Required):

Number of individuals with SMI or SED referred to BHCS treatment system (includes county and CBO providers): 266

List type(s) of treatment referred to:

- Language Acute Crisis Care & Evaluation for System-wide Services (Language ACCESS) Program such as Asian ACCESS Program; La Clínica's ACCESS Program
- Adult Level 1 Service Team Program
- Adult Outpatient Therapy Program
- Childrens Level 1 Program; Children's Hospital
- Early Childhood Program
- Medication Only Clinic (e.g. Pathway to Wellness)
- Integrated Behavioral Health in Primary Care Setting
- Sausal Creek Urgent Medication Clinic
- Mobile Crisis Team for home-based crisis evaluation
- Psychiatric Emergency Hospital (e.g. John George Psychiatric Pavilion, Willow Rock)
- CalWORKs Program

Number of individuals who followed through on referral & engaged in treatment: 152
Average duration of untreated mental illness: Unable to calculate at this time. Standard Deviation: N/A
Average time between referral and participation in treatment: Unable to calculate at this time. Standard Deviation: N/A

Improving Timely Access to Services for Underserved Populations Strategy (Required):

Target population: Low income Latinos in Alameda County
Number of referrals to a Prevention program: 32
Number of referrals to an Early Intervention program: 266
Number of individuals followed through on referral & engaged in early intervention treatment services: 152
Average time between referral and participation in treatment: Unable to calculate at this time.
Standard Deviation: N/A

Access and Linkage to Treatment Strategy (Required):

Number of referrals to **BHCS treatment system** (beyond early onset): NA
Number of individuals followed through on referral & engaged in treatment: NA
Average time between referral and participation in treatment: NA Standard Deviation: NA

As required for each Prevention Program:

Implementation Challenges:

At this time La Clínica does not have an electronic health record (EHR) that allows La Clínica to capture the abundance of the patient data requested. However, this data is entered into INSYST at the time of registration, but not available at the client level. In addition, successful linkage to lower levels of care is inconsistent as there does not exist a clearinghouse or updated database of these providers. Lastly, Medicare-MediCal recipients also comment on increased challenges with seeking mental health services as they often do not understand that when selecting their health plans they are also selecting mental health providers.

Success:

In FY 17-18, 506 clients received an assessment. Of these clients, 152 received a referral to a group, 29 received a referral to La Clínica's Prevention and Early Intervention program, Cultura y Bienestar, 158 received a referral to specialty mental health care such as La Clínica's Adult Outpatient Level I Service Team Children's Outpatient Level I Services, 13 were referred for Ryan White services, 14 received a referral to La Clínica's child abuse program, 32 were referred to other programs such as ACCESS, Beacon, Pathways, Kidango, or Level III Services.

La Clínica has a model for open access where an appointment to be seen for an initial evaluation is not necessary.

Lessons Learned:

It is difficult to refer mild/moderate Spanish language clients due to inadequate bilingual and bi-cultural providers in the community. In addition, it has been difficult to recruit bilingual/ bi-cultural clinicians who can afford to live in the area.

Relevant Examples of Success/Impact:

A 39 year old Latino male client presented at Casa del Sol with ongoing symptoms of psychosis. This individual had never been in treatment despite entering into the California Youth Authority and later the adult corrections system at the age of 15. His symptoms of schizophrenia were never consistently treated and resulted in years of instability. To date, the client has engaged in treatment, and is on a successful medication regimen and is in the process of repairing family relationships and working on his recovery from substances. He is motivated to engage with vocational rehab to investigate work opportunities.

Additional Information:

In this section please include the number of clients and/or contacts you estimate to serve in:
FY 17/18: 3835 hours of service to 480 unduplicated clients
FY 18/19: 3835 hours of service to 480 unduplicated clients
FY 19/20: 3835 hours of service to 480 unduplicated clients

Any changes you intend to make to your program over the next three fiscal years:

La Clinica is moving to Clinician's Gateway in August 2018 and in the next 3 years plans to move to a full EHR.

Stigma and Discrimination Reduction Program

PEI Data Report FY 17/18

As required for each Stigma and Discrimination Reduction Program:

MHSA program Number: **PEI 4**

Program Name: **Stigma & Discrimination Reduction Campaign- Everyone Counts Campaign (EEC)**
http://www.everyonecountscampaign.org/

Program Description: The ECC aims to reduce stigma and discrimination against people with mental health challenges and to promote social inclusion through three strategies: Empowerment (Healing Arts, and Spirituality groups), Outreach (Lift Every Voice and Speak, Action Team, outreach events), and Communications (website, email, social media).

Available number of individuals reached: 1,914 excluding communications activities; 384,905 including communications.

List number of individuals reached by each activity (ex: # who accessed website, tabling/outreach events, eblasts, etc):

Type of Activity (ex: accessed website)	**Number of Individuals Reached** (#)
ECC Empowerment: Healing Arts (Reflections & Expressions) and Spirituality Groups	87
ECC Outreach: Lift Every Voice and Speak Participants at Meetings	28
ECC Outreach: Lift Every Voice and Speak Speaking Engagements	285
ECC Outreach: Latino American Action Team (LAAT) Meetings & Activities	42
ECC Outreach: Latino American Action Team (LAAT) Anti-Stigma Groups	37
ECC Outreach: Events and General Outreach Efforts	1,412
ECC Communications: Email Blasts, Policy/Media Updates	2,504 subscribers
ECC Communications: Website visits	6,416 visits
ECC Communications: Program Articles/Blogs/Updates	366,071 est. reached
ECC Communications: Hard copy calendar updates	8,000 est. reached

Demographics

Report disaggregate numbers served, number of referrals for treatment and other services for the following categories:

Note from PEERS: These numbers include participants in ECC Empowerment (Healing Arts and Spirituality Groups, ECC Outreach: (Lift Every Voice and Speak Participants, LAAT Meetings & Activities and Anti-Stigma Groups) *only*

Age Group

Children/Youth (0-15)	3
Transition Age Youth (16-25)	11
Adult (26-59)	36
Older Adult (60+)	12
Declined to Answer	132

Race

American Indian or Alaska Native	0
Asian	4
Black or African American	32
Native Hawaiian or other Pacific Islander	0
White	22
Other	1
More than one race	2
Declined to Answer	133

Ethnicity (Cultural Heritage)

Hispanic or Latino as follows:	
Caribbean	1
Central American	0
Mexican/Mexican-American/Chicano	0
Puerto Rican	0
South American	0
Other	0
Declined to Answer	84
Non-Hispanic or Non-Latino as follows:	
African	
Asian Indian/South Asian	
Cambodian	
Chinese	1
Eastern European	
European	
Filipino	
Japanese	
Korean	
Middle Eastern	
Vietnamese	
Other	
More than one ethnicity	1
Declined to Answer	132

Primary Languages

English	115
Spanish	79
Chinese Dialect	
Japanese	
Filipino Dialect	
Vietnamese	
Laotian	
Cambodian	
Sign ASL	
Other Non-English	

Sexual Orientation

Gay or Lesbian	
Heterosexual or Straight	
Bisexual	
Questioning or unsure of sexual orientation	
Queer	
Another sexual orientation	
Decline to Answer	194

Disability

Yes	
Communication Domain:	
Difficulty Seeing	
Difficulty hearing, or having speech understood	
Other (specify)	
Mental Domain	
Physical/Mobility Domain	
Chronic Health Condition	
Other	
No	
Decline to Answer	194

Veteran Status

Yes	
No	
Decline to Answer	194

Gender

Assigned sex at birth:	
Male	
Female	
Decline to Answer	194
Current Gender Identity:	
Male	68
Female	118
Transgender	0
Gender queer	0
Questioning or Unsure of Gender Identity	0
Another Gender Identity	5
Decline to Answer	0

Implementation Challenges:

LEVS participants were having challenges completing Toastmaster assignments outside of regular meetings, and the curriculum was not satisfying our goal of reducing internalized stigma. PEERS is interested in increasing attendance in our various programs. To this end, we have decided to invest in more personal contact with other agencies to promote our services rather than relying so heavily on tabling and email/social media outreach. Our expectation is that building these relationships will help the community stay in touch more with all the programing PEERS has to offer. In the wake of the Cambridge Analytica scandal, Facebook announced in April that it would tweak its algorithm and downgrade posts that originate from groups and pages. As a result, it is now much more difficult to gain traction on Facebook for promotional and outreach content.

Successes:

The Latino Alliance Action Team (LAAT) anti-stigma groups had an important positive impact on the participants with regard to Depression and Social Support outcomes; ***Depression symptoms in particular were reduced by 20%.***

<u>One stigma concept "Self-respect loss due to Stereotypes" dropped by 20% as a result of the group.</u>

PEERS attended 36 events during the 2017-2018 contract year to spread the ECC message and materials in the community. At these events we engaged over 1,400 community members. We focused on attending events reaching specific underserved groups including the African-American community, Latino/a/x community, LGBTQ community, Chinese-American community, and individuals involved in the criminal justice system.

Lessons Learned:

Healing arts is now one of our smaller programs, however community feedback and evaluations indicate that the facilitator and activities are thoughtful, engaging and healing. Next fiscal year, we are excited to merge healing arts and our spirituality group to create a strong spirituality program that will introduce various healing methods to group participants as a complement to their spiritual practices. We plan to conduct these workshops off-site to reach more participants and to establish PEERS as a mental health resource in spiritual/faith communities.

A focus group with LEVS participants revealed that the group positively impacted participants' wellness, ability to tell their story and/or advocate for themselves, and connect to resources. We switched from the Toastmasters curriculum and to Pat Corrigan's Coming Out Proud (COP) curriculum, which encapsulates all areas of LEVS' learning objectives. Since we changed our curriculum, we continue to receive positive verbal feedback.

The Everyone Counts Campaign encourages access to services by promoting PEERS' keystone service, Wellness Recovery Action Planning (WRAP), and through our collaborative relationships with other service providers in Alameda County.

Relevant Examples:

PEERS had the great pleasure of being able to host a free public screening of The S Word, a documentary film following suicide attempt survivors who have become suicide prevention advocates. After the screening, we held a panel with the film's director, Lisa Klein, the director of Crisis Support Services of Alameda County, Nancy Salamy, and Kelechi Ubozoh, a former PEERS employee and an attempt survivor featured in the film. 52 people attended the screening and had poignant questions for the panel about how the film became what it was and how suicide affects our community. In addition to raising awareness about suicide, we also were able to spread awareness of PEERS and our programming.

Facebook Cover Video: In January, we added a cover video to our Facebook page that highlights PEERS' programs and mission to confront mental health stigma in Alameda County. This video adds visual flair to our profile, thereby increasing traffic to ECC-related content.

Black History Month: In February, 2018 we released an abundance of online content commemorating Black history and African American contributions to the mental health consumer movement. These included eight original social media posts, a Media Alert and a video and article covering the ACBHCS and POCC Annual Black History Month Celebration and Training.

Additional Information:

In this section please include the number of clients and/or contacts you estimate to serve in:
FY 18/19: reach a minimum of 2,000 participants, excluding communications activities
FY 19/20: reach a minimum of 2,100 participants, excluding communications activities
FY 20/21: reach a minimum of 2,200 participants, excluding communications activities

Any changes you intend to make to your program over the next three fiscal years:

We plan to implement a process where we can track referrals made during groups and follow-ups that happen.
Over the next three years we plan to increase outreach efforts to reach communities that we are not currently serving.

In FY 18/19 we will create a three-year outreach strategy that includes an increase in participants reached each year. Our goals are:

- Partner with OUSD to provide support to High School and Junior High students through WRAP and our ECC campaign.
- Partner with older Adult communities specifically targeting isolated older adults in board and care homes and senior centers.
- Partner with Foster care and Criminal Justice systems to outreach to these communities.
- Partner with organizations that support Immigrant communities to educate on mental health and wellness. We plan on training bilingual people in this community on WRAP so that we can hold groups in other languages.

Suicide Prevention Program
PEI Data Report FY 17/18

As required for each Suicide Prevention Program:

MHSA program Number: **PEI 12**

The Program Name: **Suicide Prevention and Trauma Informed Care- Crisis Support Services of Alameda County Text Line Program**

Available number of individuals reached: Duplicated individuals: 887 text sessions

List number of individuals reached by each activity (ex: # who accessed website):

Type of Activity (ex: accessed website)	**Number of Individuals Reached** (#)
Offer the ability for Alameda County residents – emphasis on youth and young adults – to contact the Crisis Line via text message between 4pm – 11pm 7 days a week: Text "SAFE" to 20121. The service is free.	887
Train laypersons and interns how to interface via text message with people in crisis, with emphasis on youth and young adults.	The number is included in CSS Crisis Line Program report

Demographics

Report disaggregate numbers served, number of referrals for treatment and other services for the following categories:

**NOTE: Obtaining demographic information on our texters is important, but in service to our mission of suicide prevention and crisis management, it will not take precedence over questions related to crisis and safety assessments. In a text session there are not as many opportunities to ask questions while also maintaining rapport and managing the crisis. This is reflected in the amount of information below.*

Age Group

Children/Youth (0-15)	131
Transition Age Youth (16-25)	70
Adult (26-59)	335
Older Adult (60+)	0
Declined to Answer	351 (majority middle or high school age)

Race

American Indian or Alaska Native	
Asian	17
Black or African American	1
Native Hawaiian or other Pacific Islander	
White	7
Other	
More than one race	
Declined to Answer	857

Ethnicity (Cultural Heritage)

Hispanic or Latino as follows: 5	
Caribbean	
Central American	
Mexican/Mexican-American/Chicano	
Puerto Rican	
South American	
Other	
Declined to Answer	5
Non-Hispanic or Non-Latino as follows:	
African	
Asian Indian/South Asian	
Cambodian	
Chinese	
Eastern European	
European	
Filipino	
Japanese	
Korean	
Middle Eastern	
Vietnamese	
Other	
More than one ethnicity	
Declined to Answer	

Primary Languages

English	887

Disability

Yes	5
Communication Domain:	
Difficulty Seeing	5
Difficulty hearing, or having speech understood	
Other (specify)	
Mental Domain	
Physical/Mobility Domain	
Chronic Health Condition	
Other	
No	
Decline to Answer	

Sexual Orientation

Gay or Lesbian	5
Heterosexual or Straight	72
Bisexual	1
Questioning or unsure of sexual orientation	
Queer	
Another sexual orientation	
Decline to Answer	809

Veteran Status

Yes	
No	
Decline to Answer	

Gender

Assigned sex at birth:	
Male	
Female	
Decline to Answer	
Current Gender Identity:	
Male	30
Female	465
Transgender	50
Gender queer	
Questioning or Unsure of Gender Identity	2
Another Gender Identity	
Decline to Answer	

As required for each Access and Linkage to Treatment Strategy:

Number of individuals with SMI referred to treatment: Unable to measure

List type(s) of treatment referred to:

COUNSELING AND OTHER RESOURCES:
- School counselors
- ACCESS
- Low fee and sliding scale sources for therapy in Alameda County
- 211
- Sausal Creek

SAFETY PLANNING:
- My3app.org
- 24/7 crisis support: Crisis Support Services crisis line, National Suicide Prevention Lifeline, Yourlifeyourvoice.org, teenlineonline.org

MENTAL HEALTH INFORMATION AND SUPPORT
- FERC
- NAMI
- Information Tip sheets from Yourlifeyourvoice.org and teenlineonline.org

Number of individuals followed through on referral & engaged in treatment: Unable to track
Average duration of untreated mental illness: N/A Standard Deviation: N/A
Average time between referral and participation in treatment: N/A Standard Deviation: N/A

As required for each Improve Timely Access to Services for Underserved Populations Strategy:

The program Name: Crisis Support Services of Alameda County – Text Line Program
Identify target population: Youth and young adults living in Alameda County experiencing crisis; all ages living in Alameda County experiencing crisis; people at risk of suicide
Number of referrals to a **Prevention** program: 0
Number of individuals followed through on referral & engaged in treatment: N/A

Average time between referral and participation in treatment: N/A Standard Deviation: N/A
Number of referrals to an **Early Intervention** program: 0
Number of individuals followed through on referral & engaged in treatment: N/A

Average time between referral and participation in treatment: N/A Standard Deviation: N/A

And/Or

Number of referrals to **treatment beyond early onset:** 0
Number of individuals followed through on referral & engaged in treatment: N/A
Average time between referral and participation in treatment: N/A Standard Deviation: N/A

Describe ways the Agency encouraged access to services and follow-through on referrals:

Texters control when they reach out to our Text Line Program. Each session usually is considered an individual session unto itself and is not part of an ongoing treatment plan. This means that we do not usually ask about texters' use of any referrals we may have given them in prior text sessions. During a text session, after giving a resource, for instance school counseling, we might ask how likely the texter is to follow through with it, and what might be an impediment and how to deal with that.

As required for each Suicide Prevention Program:

Implementation Challenges:

- Expanding capacity to take more texts
- Expanding hours of operation
- Expanding outreach to target population and then be able to accommodate increased capacity
- Expanding outreach without use of social media/web so that we can expand reach beyond Alameda County

Successes:

- Offering a free resource to Alameda County residents to be able to connect with counselors trained in suicide prevention, crisis intervention, cultural humility, trauma informed perspectives, and with a special emphasis on youth and young adults
- Offering a text based way to interact with trained crisis counselors – this allows for greater autonomy, access for some, and sense of anonymity.
- Stigma reduction: Counselors are trained in person-centered, person-first, and strength-based ways of interacting with at risk populations. The ability to interface via text rather than voice calls can be helpful for some people who are experiencing stigma.

A sampling of what texters say:

- "You guys helped me wanna live."
- "I do feel a lot better right now and I do feel so much better than I did at the beginning of this evening. Thank you so much for listening to me."
- "This has really helped me work things out. Thanks for letting me talk. :)"
- "Thanks for the links and no, I don't feel the urge to cut."
- "Sure. Thank you for offering the resources that could help me."
- "Thank you. Having that plan gives me a goal to get to."
- "Thank you. I just called Sausal and found out how we can get her seen this weekend. Thank you so very much."
- "Idk what else to say but THANK YOU!!!!!You have been an amazing supporter and I'm glad I talked to you today."
- "I feel more at ease now that I was able to talk out some of my feelings. Thank you very much for sparing your time to help me."
- "Thank you I will do my best and I will contact this line in the future. Referring back to these texts will help me in those situations. thank you so much again."
- "Thank you. I'm going to go to sleep. I appreciate you a lot and that you do this for the society we live in."

Lessons Learned:

TRAINING: This year the Text Line Program expanded the volunteers who are trained for text by developing a special cohort trained just on texting. This allowed for a more in depth level of training. In the process, we learned that the techniques and spirit of Motivational Interviewing, an evidence based approach, is a great fit for texting, especially with the youth and young adult population. We will continue to develop this training.

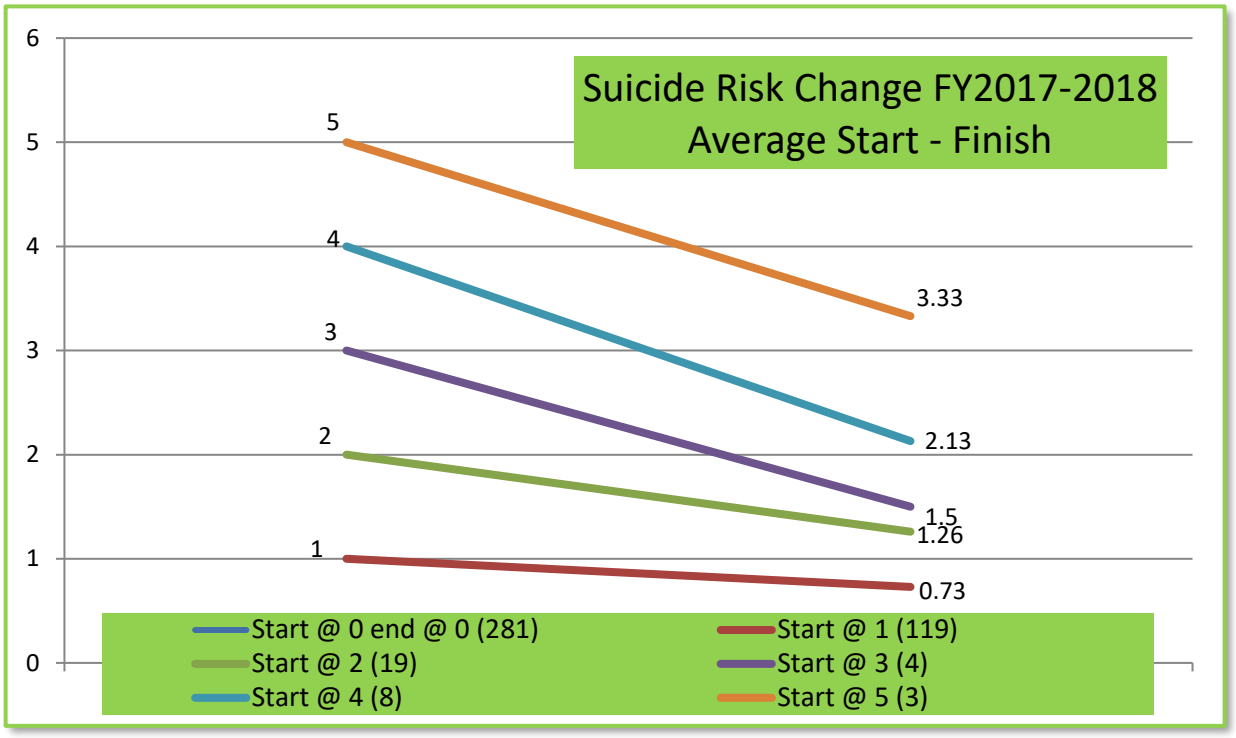
Relevant Examples: Below are examples of what counselors are able to do via a text session for suicide prevention:
*Any reference to texters are anonymized for confidentiality. Often the pronoun will be "they" and other identifiers will have been changed. Below are a few examples of text sessions.

Text Session Example:
A text session started with a texter opting in by texting "SAFE" to 20121. The texter received several auto messages identifying who they had texted in to and a link for more information about our service. Then a counselor came on the line and validated the texter for choosing to text in and asked how they were doing.
The texter responded:
Texter: "I'm really stressed and everything is just so overwhelming right now"
The texter confided to the counselor that they were having difficulties with a relationship and that they felt that their partner was no longer interested in them. The texter also revealed that they had difficulty letting others know how they were feeling:
Texter: "I feel like I was just a burden to him. And a burden to my family who have to deal with my moods."
A little ways in to the session, the counselor introduced herself and gave her name and asked if the texter would feel comfortable sharing their name. The texter responded with their name and how they found out about the text line:
Texter: "I'm John. We had a little mini assembly during class, which is where I got this number."
The texter confided more about their situation. At this point the texter focused mainly on their difficult romantic relationship. They were having a hard time opening up to their partner and did not want to burden them. Yet this was resulting in a feeling of isolation and disconnection. The counselor reflected the texter's feelings:
Counselor: "It's so tough when you're doing so much to be there for someone you care about, but are also feeling overwhelmed with your own emotions, and I'm really glad you reached out for some support tonight"
The texter then revealed that they experience suicidal ideation:
Texter: "I don't want to die, but I don't want to live and deal with all this."
The counselor continued to assess the texter:
Counselor: "Can I check in and ask if lately it's gotten painful enough that you've been thinking of ways you'd kill yourself?"
Texter: "It hasn't gotten that bad yet, but I'm afraid that it might get that bad."
While the texter was having difficulty speaking to their family about their internal states, the texter also spoke of strengths they had and supports that they had built in to their life, such as consistently taking psych medication and having just started therapy.
Then the texter focused on how to open up to their supports in their life (in addition to the therapist) and the session ended with the texter deciding what they would tell the others.
At the end of the text they wrote:
Texter: I have to go, but what time does this hotline end? And is it open every day?
Counselor: "It's open until 11pm and every day 4pm - 11pm. I hope you keep checking back in!"
Texter: "Thank you so much."

Chart of suicide risk level changes

Counselor Rated Suicide Risk Change - From Start to Finish

Below is a chart of counselor ratings for suicidality change at the beginning to end of sessions.



EXPLANATION OF SUICIDE RISK 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

C. INNOVATIVE (INN) PROGRAM SUMMARIES

Innovative (INN) Program Summaries

Innovative Programs are intended to provide mental health systems with an opportunity to learn from innovative approaches. Innovation Programs are not designed to support existing or ongoing programs or services, but rather to provide the mental health system with innovative demonstration projects that will support system change in order to increase access to services and improve client/consumer outcomes.

An Innovative Project may introduce a novel, and/or ingenious approach to a variety of mental health practices. Innovative Projects can contribute to learning at any point across the spectrum of an individual or family's needs relating to mental health, from prevention and early intervention to recovery supports.

An Innovative Project must meet the following criteria:

1. It is new, meaning it has **not** previously been done in the mental health field;
   Innovation Projects must promote new approaches to mental health in one or more of the following ways:

   - Introducing a new mental health practice or approach, or
   - Adapting an existing mental health practice or approach, so that it can serve a new target population or setting, or
   - Modifying an existing practice or approach from another field, to be used for the first time in mental health.

2. It has a learning component, which will contribute to the body of knowledge about mental health.

   - The learning component is represented in the application's Learning Question.

Before Innovation funds can be spent on an Innovation project, the project idea must be vetted through a 30 day public review process, approved by the County Board of Supervisors and then approved by the Mental Health Services Oversight and Accountability Commission (MHSOAC). The first two steps may take place as part of a Three Year Plan or Plan Update or may be implemented as a stand-alone process.

Summary of Changes

1. INN Programs Under Procurement

A. Community Assessment and Transport Team (CATT)

Alameda County's existing system for responding to behavioral health crises in the community is inefficient in terms of expense, time and connecting clients to appropriate services. A vast majority of transports for individuals on a psychiatric hold are conducted by ambulance, which is expensive and requires law enforcement to wait for an ambulance to arrive. These calls are lower priority since they

are generally not life-threatening, therefore increasing the wait time. In addition, the existing system transports an individual who qualifies for a 5150 involuntary hold, but those who do not qualify are left on site without a connection to services.

The proposed Innovation Project will improve access to services in Alameda County by bringing together a few efforts to significantly transform the response to behavioral health crises in the community:

- Develop a crisis response team that includes Behavioral Health Clinicians and an Emergency Medical Technicians (EMT) in order to provide both medical and behavioral health assessments in the field, including in a medical emergency department. This team will initially be available 16 hours a day, 7 days a week, and focus on two communities that are identified as "underserved". The team will be able to provide transport for involuntary (5150 holds) as well as voluntary clients to the appropriate services, including psychiatric hospital, emergency department, crisis residential, sobering center or other site.
- Enhance the bed availability software program (Reddinet) to show availability of psychiatric, crisis stabilization units, and sobering center beds and provide alerts when the psychiatric emergency services are reaching capacity in order to provide real time information about the availability of disposition options.
- Provide access to tele-psychiatry for the crisis response team in the field.
- Provide the crisis response team with access to a Community Health Record through AC Care Connect, which enables them to send an alert about the episode to other providers involved with the client.

By bringing together the right staffing and the right technology, this innovative crisis response team will reduce unnecessary 5150 holds, transportation to medical facilities for medical clearance, and the many hours of waiting for clients and first responders. In addition, it will increase access to appropriate services by connecting and transporting clients whether or not they are on a 5150 hold.

B. Transitional Age Youth (TAY) Emotional Emancipation Circles (EEC)

Emotional Emancipation Circles℠ (EEC) are support groups designed for African American people to "work together to overcome, heal from, and overturn the lies of White superiority and Black inferiority." This Innovation project will:

- Tailor the EEC model to specifically target the needs of African American young adults, while ensuring fidelity to the model, and
- Evaluate mental health and functional outcomes: The current EEC evaluation process focuses on participant satisfaction. By expanding the scope of the evaluation we can determine if young adults felt engaged and if it resulted in positive mental health and functional outcomes.

2. Previously Approved INN Programs Under Development for Future Procurement

A. Introducing Neuroplasticity to Mental Health Services for Children

Many children with emotional and behavioral disorders have underlying neurodevelopmental

differences, often caused by trauma, which exacerbate the emotional and behavioral disorders. Finding a way to provide neurodevelopmental interventions, in addition to mental health interventions, should lead to better mental health and functional outcomes.

This Innovation proposal integrates a neurodevelopmental approach into mental health services to achieve better outcomes. Holistic Approach to Neuro-Developmental Learning Efficiencies (HANDLE®) is a practice based on brain research on neuroplasticity and the effect of stress responses on learning, mood and behavior. It includes an initial assessment to determine inefficiencies in the communication between the body and the brain leading to functional difficulties. Based on that assessment a treatment plan is developed that specifies interventions to address the neurodevelopmental weaknesses. HANDLE does not teach coping mechanisms, it improves brain function, which ultimately reduces or eliminates the underlying neurodevelopmental problems contributing to emotional and behavioral symptoms.

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

The changes in the laws regarding cannabis use in California provide an opportunity to find proactive ways to address the potential impact on mental health. Alameda County proposes a collaborative approach to reducing potentially harmful effects on TAY mental health consumers. The focus of this proposed Innovation Project is to collaborate with key stakeholders, including TAY consumers and the cannabis industry. Developing a positive and proactive collaboration with the cannabis industry is a unique approach to supporting the health of TAY consumers.

Two policy development advisory committees will be formed:

1) One will include representation from providers (hospitals, health clinics, Alameda County departments, etc.), law enforcement (parole, probation, court, jail, etc.), education (public schools, college, vocation schools, etc.), and the cannabis industry. This committee will focus on determining best policies and practices among these institutions.
2) One will include TAY mental health consumers, family of consumers and community members. This committee will focus on better understanding cannabis usage by TAY consumers and best practices for education campaigns, as well as providing input on the work of the policy and practices committee.

The results of this process are expected to lead to:

1) A model for working with the cannabis industry to develop and implement best practices to support the health of mental health consumers
2) A well-informed and collaborative harm reduction approach to cannabis usage for TAY consumers that is responsive to the current legal environment regarding cannabis.

3. New INN Programs under Development for Future Procurement

Alameda County Behavioral Health Care Services (ACBHCS) is currently developing multiple proposals for the Innovation component of the Mental Health Services Act. A summary of the proposed concepts to date are provided here. These will be further developed and discussed with the Mental Health Services

Oversight and Accountability Commission (MHSOAC) staff for technical assistance. Those proposals with a strong Innovation aspect will be written up in detail, published for 30 day public comment and then submitted to the Alameda County Board of Supervisors and the MHSOAC for final approval. Please note, additional Innovation projects are being internally developed based on the 2017 summer community input sessions and may be included when all Innovation projects are posted for the 30 day review period.

A. Supportive Housing Community Land Alliance

Across the Bay Area, an inadequate supply of housing stock, particularly affordable housing, has contributed to rising home prices, rental rates, evictions, displacement and homelessness. Over the past five years, there have been significant declines in the number of licensed board and care facilities, residential hotels, and room and board facilities frequently utilized by individuals living on fixed incomes. Individuals with severe mental illness living on fixed Social Security disability incomes experience some of the greatest challenges in finding and maintaining housing in this region.

A Community Land Alliance (CLA), which will be based on a community land trust model, would be a nonprofit, community-based organization designed to ensure community stewardship of land. Community land trusts are often associated with conservation efforts, but there is also a significant effort to ensure affordable long-term housing through this form of ownership. The alliance will acquire land and maintain ownership of it permanently. The CLA enters into a long-term, renewable lease with residents. When the resident leaves, they earn a portion of the increased property value. The remainder is kept by the trust, preserving the affordability and purpose of the property for future households.

The proposed Innovation Project will promote interagency collaboration to create an **Alameda County Supportive Housing Land Alliance** to develop and maintain supportive housing units. ACBHCS will partner with the Alameda County Housing and Community Development Department, housing and real estate legal and financial experts, consumer/client representatives, family member representatives, and existing nonprofit affordable housing developers to develop a land trust that is focused on supportive housing that incorporates unique aspects in order to address local conditions.

4. Innovation Grant Projects Completed

Project Name: K-Stories, Our Stories

Grantee: Korean Community Center of the East Bay

Project Description: An INN Grant project was implemented in FY17/18 to develop a culturally responsive drama intervention to reduce stigma among Korean older adult immigrants and develop leadership among TAY and young adults. The project leverages the popular cultural medium of Korean Drama to elicit discussions, exploration and critical thinking around mental health issues and topics affecting the target populations receiving the intervention.

Learning Question – How can the use of culturally-resonant and popular program content be leveraged to reduce stigma of mental health issues and topics for Korean older adults (age 60+)

and Asian Pacific Islanders young adults (ages 16-24)?

Round Four Innovation Grant Projects

Program Name: INN 4B. Behavioral/Mental Health Career Pathways for High School and Undergraduate Students

Program Description: The MHSA INN Behavioral/Mental Health Career Pathways will address challenges and barriers in building cohesive, effective academic and career pathway programs to attract, recruit, train and retain culturally, linguistically and economically diverse individuals into the public behavioral/mental health field. This project is intended to focus on students at the high school, community college and/or undergraduate level who have demonstrated interest in exploring behavioral/mental health careers.

Refer to Workforce, Education, and Training (WET) section for details and updates regarding this project.

Program Name: Innovations In Reentry

Program Description: Innovations In Reentry

FY 17-18 Plan Update:

Innovations In Reentry Round 2

In July 2016, Alameda County Behavioral Health Care Services awarded $1,029,497 in funding for Round 2 of the Innovations In Reentry Grant Program. The Funding Board, which consisted of reentry experts from local government agencies, community-based organizations, and community stakeholders, recommended seven projects implemented by twelve community-based organizations. Two of the projects were implemented from July 2016 through December 2016, and are not included in this report.

Re-entry Workforce Development for Peer Services (18 month grant period) – Effective and adoptable plans for incorporating formerly incarcerated individuals into the workforce of agencies and programs providing services to the reentry population.

Innovations In Reentry Mini-Conference

On May 7, 2018, the Innovations In Reentry Mini-Conference was held at Alameda County Behavioral Health Care Services in Oakland. The five grantees who implemented pilot projects in the Re-entry Workforce Development for Peer Services Category presented their outcomes and what they learned through implementation. Consumer representatives from each program also shared their experiences as part of a panel. In addition, the conference featured as keynote speaker a formerly incarcerated individual who became a reentry peer specialist through the support of similar programs. Finally, the contracted evaluator presented an overview of the evaluation results, including how the learning objectives of the projects were met. Over 150 individuals attended the conference, including consumers, family members, providers, public protection staff, advocates, local policymakers, and other community members attended the event.

C. INNOVATIVE (INN) PROGRAM SUMMARIES

Innovations In Reentry Round 2 Evaluation

In January 2018, The Bridging Group started the evaluation process for the grantees in the Re-entry Workforce Development for Peer Services category. The evaluators 1) collected qualitative data through interviews with project staff and participant focus groups and 2) reviewed quantitative data gathered from grantees during the course of project implementation. The Bridging Group then compiled and analyzed the information to draft a comprehensive report. The evaluation showed that the programs were successful in working with one of the most vulnerable populations. In addition, county-sponsored projects need to meaningfully integrate communities and families, in order to be successful.

Project Name	Grantee	Project Description
Reentry Workforce Development for Peer Services (July 1, 2016 to December 31, 2017)		
1. Reentry Navigators	Asian Prisoner Support Committee & Building Opportunities for Self Sufficiency	Program model to train qualified peer specialists for case management contracts, using cross-racial dialogue and partnership
2. Community Mental Health Worker Training	Conscious Voices	Program model to train formerly incarcerated women to be community health workers
3. Women Far Above Rubies	E C Reems Community Services	Program model to train qualified peer specialists for case management contracts, focusing on women
4. The Fresh Start Initiative	Genesis Worship Center & Tri-Cities Community Development	Program model to train qualified peer specialists for case management contracts, starting pre-release in jail
5. Trauma Informed Specialists	Oakland California Youth Outreach	Program model to train peer specialists to provide case management services with trauma-informed care

D. WORKFORCE, EDUCATION & TRAINING (WET) PROGRAM SUMMARIES

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 17/18 Outcomes, Impact & Challenges:

- The Workforce Education and Training (WET) team administered and implemented previously approved WET strategies such as the Graduate Intern Stipend Program, High School Career Pathways activities, and the State Mental Health Loan Assumption Program (MHLAP).

- WET manager provided oversight of the High School Career Pathways contract with La Clinica de La Raza, eight Innovation and WET High School and Undergraduate Pathways contracts as well as the Bay Area Regional Workforce Partnership contract.

- BHCS continues to serve as the fiscal sponsor for the Bay Area Regional Partnership program as outlined in the Office of Statewide Health Planning and Development (OSHPD) Agreement Number 14-5004, which includes passing through the funds to California Institute for Behavioral Health Solutions (CIBHS). WET manager continued to provide contract oversight.

- The WET team collaborated with various primary applicant organizations including Mentoring in Medicine and Science (MIMS) and Diversity in Health Training Institute on applying for the OSHPD Mini Grants as a collaborative partner – both organizations received funding.

- Amended standard service agreement with BHCS and the University of California, San Francisco (UCSF), School of Medicine to provide behavioral health education and clinical training to Fellows from UCSF Public Psychiatry Fellowship (PPF) Program. This agreement provides an opportunity for fellows to consider public mental health as a career choice with an objective of recruiting viable candidates into BHCS system of care. BHCS Trust Clinic provided PPF fellow(s) beneficial educational opportunity at the Trust Clinic, at the same time, enabled BHCS to develop a recruitment pipeline for BHCS system of care in need of psychiatrists.

- WET Staff continued to provide administrative functions for Children and Youth System of Care (CYSOC), and Criminal Justice Mental Health Services/Conditional Release Program (CONREP) internships.

D. WORKFORCE, EDUCATION & TRAINING (WET) PROGRAM SUMMARIES

(Continued…Workforce Staffing Support; FY 17/18 Outcomes, Impact & Challenges)

- WET Training Officer served on the BHCS Training RFP Review Committee. Reviewed and scored grant applications.
- WET manager and staff attended and actively participated in the Bay Area WET Collaborative meetings; twice monthly WET coordinator conference calls.
- WET manager actively participated in the Regional Partnership Workforce Education and Training (WET) Steering Committee meetings.
- WET staff served on various BHCS advisory committees, such as the BHCS Training Committee, Latinx Behavioral Health Workforce Action Group, Immigrant and Refugee Workforce Workgroup, WET Regional Partnership Steering Committee, Alignment Bay Area Health Pathways, East Bay Behavioral Health Workforce Workgroup and the Berkeley City College Human Services Program Advisory Committee.
- WET manager successfully completed the CIBHS Leadership Institute – class of Spring 2018.
- Organized and conducted an annual WET Needs Assessment Survey.

FY 18/19 Progress Report

- BHCS WET completed the 10 year MHSA block grant at the end of FY2017-18. BHCS is committed to continue WET activities and WET is currently funded through the MHSA Community Support Services (CSS). WET is currently focusing on workforce capacity building through behavioral health career pipeline development, training opportunities, and addressing strategies to recruit and retain hard to fill positions, increasing diversity, bridging gaps in skills set and improving language capacity.
- BHCS WET and INNOVATION provided funding to eight grantees to implement mental/behavioral health career pathways pilot projects for eighteen months from October 2017 through March 2019. The total allocation for the project is $2,129,203. These pilot projects are funded by MHSA INN to provide educational and training opportunities to underrepresented and disadvantaged high school and community college students to gain experience in the Public Mental/Behavioral Health. MHSA INN funding intended to provide the mental health system with an opportunity to learn from innovative approaches.
- WET INN Collaborative Project hired a qualified consultant to provide technical assistance to WET INN Internship Pilot Projects for high school and college students.
- Planning and coordinating INNWET Learning Conference on February 15, 2019. All grantees will have an opportunity to share their learning experiences, successes and challenges with stakeholders, institutions and policymakers. The goal is to educate that systems need to be reformed so that students who come from historically traumatized backgrounds can be included in the mental/behavioral health workforce. By educating these stakeholder groups the hope is that sustainable partnerships and funding can continue to grow.
- BHCS WET manager is currently working in collaboration with the Merritt College Deans of Liberal Arts and Social Sciences and Allied Health. The purpose of this partnership is to help the College develop a Behavioral Health Pathway and assist them with the implementation of the wellness, recovery and resiliency focused curriculum developed by BHCS WET.

D. WORKFORCE, EDUCATION & TRAINING (WET) PROGRAM SUMMARIES

(Continued…Workforce Staffing Support; FY 18-19 Progress Report)

- BHCS WET hosted 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. Provided internship opportunity to two undergraduate students from UC Berkeley Public Health from June 11 through August 17, 2018.
- WET conducted an assessment of workforce and training needs with BHCS County and contracted community based organizations (CBOs) through an online survey and a focus group to gather feedback from stakeholders.
- MHSA Division Director participated in and provided input at the 2020-2025 Mental Health Services Act Workforce Education and Training (WET) Five-Year Plan development.
- WET manager participated in the State WET Evaluation/Workforce Needs Assessment Survey and provided written information to OSHPD.
- WET team continues to prioritize, develop and implement projects based on the 2017 workforce needs assessment survey outcomes.
- Continues to evaluate WET program impact and needs; based on program outcomes and data, continues to enhance and implement activities to achieve WET goals.

FY 19/20 Anticipated Changes:

- BHCS WET is currently funded through the MHSA Community Support Services (CSS). Following the 2017 workforce needs assessment findings, WET is currently focusing on workforce capacity building through behavioral health career pipeline development, training opportunities, and addressing strategies to recruit and retain hard to fill positions, increasing diversity, bridging gaps in skills set and improving language capacity. ***(To view the 2017 Workforce Needs Assessment report in detail, see Appendix B.)***

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 17/18 Outcomes, Impact & Challenges:

- BHCS WET, the ***Office of the Consumer Empowerment*** (OCE), and the Pool of Consumer Champions (POCC) partnered with Merritt College's Medical Assistant Program. WET provided financial support to four POCC members who attended the Medical Assistant Program at Merritt College and they graduated in May 2018 with Medical Assistant Certificates.
- BEST Now, a program with Alameda County Network of Mental Health Clients (ACNMHC), provides peer specialist training program with 6 month internships: 23 students are attending the program and scheduled to graduate in June 2019.

D. WORKFORCE, EDUCATION & TRAINING (WET) PROGRAM SUMMARIES

(Continued… Consumer & Family Training, Education and Employment; FY 17/18 Outcomes, Impact & Challenges)

- POCC Consumer Employment Advisory Taskforce (CEAT) provided a workshop on *Rediscovering Ourselves, Exploring Our Dream Jobs* to 45 individuals.

- POCC partnered with California Association of Mental Health Peer Run Organizations (CAMHPRO) to leverage state dollars to bring more trainings and employment opportunities to consumers. Two cohorts have completed the trainings and the last cohort is expected to finish training by November 2018. The POCC will be hiring 15-18 staff from all cohorts, and are currently receiving the first round of applications.

- The POCC and the OCE coordinated two certified Forensic Peer Specialist Trainings in collaboration with Pennsylvania Mental Health Consumer Association using Drexel University's curriculum and the SAMHSA Gains Center.
    - The first training was an 18-hour Advanced Forensic Peer Specialist Training which took place in April 2018 with 35 attendees.
    - The second training was a Forensic "Train the Trainer" course in April 2018 with 35 attendees.
- Advanced Peer Specialist trainings/educational experiences funded to build knowledge, skills and abilities including with the following:

    - 2-DAY Dialectical Behavioral Therapy Kickoff Training with trained facilitator from the Linehan Institute with18 participants.

    - DBT 32-hour online training series for 60 participants. Outreach and orientation in process; training can take place over one-year and is self-paced.

    - Pat Deegan Hearing Voices Simulation Exercise; 20 pre-loaded mp3 players (reusable); outreach & facilitation in planning.

- The ***BHCS Office of Family Empowerment (OFE)*** provided 2 day coaching skills training to support Family Partners and their Supervisors to increase communication, collaboration, connection and humility in service delivery to families and in the workplace.

- OFE implemented 18 hours of on- site technical assistance and coaching to Family Partners and Supervisors in three early childhood mental health agencies to practice and integrate coaching skills introduced at the two day coaching training. The training and technical assistance resulted in a greater awareness and self-management of triggers especially related to trauma and high stress situations, a shift from solving problems to supporting family strengths and internal resources, and increased collaboration, communication and connection between Family Partners and their Supervisors.

FY 19/20 Anticipated Changes:

- Employment Liaison's position is no longer funded by BHCS WET and currently located within the Office of Consumer Empowerment. The role of this position changed and have a larger scope than building consumer employment in behavioral health.

D. WORKFORCE, EDUCATION & TRAINING (WET) PROGRAM SUMMARIES

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 17/18 Outcomes, Impact & Challenges:

- Provided or collaborated on a total of 78 training activities, thereby training 2,614 staff and providing 381 continuing education hours to BHCS and contracted provider staff.
- Training topics were provided on a variety of issues including legal and ethical issues, Culturally Responsive Mental Health Services for Sexual Orientation and Gender Identity (SOGI), Tobacco Cessation Interventions, Adult and Youth Suicide Assessment & Intervention, Coaching for Collaboration, Commercially Sexually Exploited & Trafficked Youth, Developing Culture-Based Wraparound for African American Transitional-Aged Youth, Navigating Systems for Adolescents with Autism Spectrum Disorder, Best Practices and Inspiration for Senior Injury Prevention Advocates, Preventing, De-Escalating, and Managing Aggressive Behavior in Behavioral Health Settings, and a variety of evidence-based practices.
- Provided trauma informed care related trainings including Becoming a Trauma Sensitive Workforce, Transforming Trauma - How to do this Work and Sustain, Preventing Vicarious Trauma, and Trauma-Informed Treatment for Adults, Children, & Teens.
- Coordinated by the Ethnic Services manager, a five-part intensive workshop series called “Caught in the Crossfire of Cultures”, which focused on the psychological problems of the Afghan population residing in Alameda County was provided.
- In collaboration with the Office of the Medical Director, a one-day Educational Summit on Cannabis was held for all health care services clinical staff including psychiatrists, physicians, and nurses.
- A full day training was provided in Farsi for County and community-based organization (CBO) staff called “Concepts of DBT and CBT as Applied to Collectivistic Culture of Farsi Speaking Populations.”
- Continue to maintain provider accreditation and offer required continuing education (CE) credit for Registered Nurses, Licensed Marriage and Family Therapists, Licensed Clinical Social Workers Licensed Professional Clinical Counselors, Licensed Educational Psychologists, Licensed Clinical Psychologists, and certified Addiction Professionals.
- Continue to provide community trainings in both Adult and Youth Mental Health First Aid.
- Training outcomes are measured using self-administered evaluations. Each training proposes measurable learning objectives to be achieved by the end of the training. Following the training, attendees evaluate whether the objectives are met using a Likert scale from 1-5 (strongly disagree to strongly agree). At the end of every training, participants are asked to complete an evaluation and if they want continuing education credit, it is required. For all trainings, learning objectives are evaluated as being met on average as at least a 4 or 5 of the Likert scale, with 5 being “strongly agree.” Other outcome measures being utilized are a post-test and for the trainings on Becoming a Trauma Sensitive Workforce, a post-training survey with 3 simple questions about the impact of training and whether changes in perspective or behavior occurred/persisted was emailed to all attendees two-weeks following the trainings.

D. WORKFORCE, EDUCATION & TRAINING (WET) PROGRAM SUMMARIES

(Continued…Training and Technical Assistance; FY 17/18 Outcomes, Impact & Challenges)

- The results of the post-training survey sent two weeks following the system-wide training on "Becoming a Trauma Sensitive Workforce", averaged over the three year period indicated that between 62% of respondents (182) were positively impacted by the training and 72% made a change because of the training.
- Because a number of units within BHCS host trainings for their staff and contracted providers, it has been a challenge to coordinate all that is necessary in order to provide continuing education credits for the numerous trainings being offered. Starting in July, we have formalized collaboration with other programs within BHCS who want CE credit for their trainings. The result of the collaboration has been more consistency and standardization for training participants. The established collaborations include the Office of the Medical Director, Ethnic Services, Substance Use Disorders System of Care (SOC), and Quality Assurance.

FY 18/19 Progress Report:

- From July 1st to October 11th 2018, the training unit provided or collaborated on a total of 17 training activities, thereby training 551 staff and providing 55 continuing education hours to BHCS and contracted provider staff.
- In June 2018, BHCS posted an Informal Request for Proposals (IRFP) for Behavioral Health Training Services with the intention to award a 1-year contract to selected Bidders in the maximum amount of $49,500. In September, the Board of Supervisors gave approval to contract with two CBOs to provide such services. Once contracts are approved, we expect to offer up to 15 trainings from November 1, 2018 through September 30, 2019 to approximately 900 county and non-county (contracted CBO) staff.
- Continue to manage a monthly meeting (8 x per year) of a 17 member Training Committee composed of representative staff and managers from county units and CBOs. The Training Committee advises the Training Officer on training activities related to both clinical and administrative staff throughout our system. Since July 1, 2018 several new members have joined the committee, including managers from the BHCS Child & Young Adult System of Care, the BHCS Adult & Older Adult System of Care, Alameda County Care Connect, and the Community Health Center Network.
- The BHCS Training Committee is beginning discussions and exploration of best practices for measuring outcomes following staff trainings and using assessment results to improve learning.
- Collaborate with the Skills Development Unit of Alameda County Care Connect, an initiative of the Alameda County Health Care Services Agency (HCSA) to improve care for residents who face the most difficult combination of physical health, mental health, and housing challenges. Will present an overview of Trauma Informed Systems to their 50-75 member Care Coordination Academy. Will also partner with the Skills Development Unit to create a 3-hour training on trauma informed care, which will be provided to the staff of the 26-agency partners that makes up Alameda County Care Connect.
- On October 5, 2018 Alameda County Health Care Services Agency (HCSA) posted an Informal Request for Proposals to seek a qualified local organization with the expertise and experience to provide HCSA with Trauma Informed Care (TIC) Training and Capacity Building Services. The plan is to have the selected organization deliver a TIC 101 train the trainer curriculum for a cohort of 10-15 trainers who will provide two TIC trainings per month. The organization will also develop a leadership training curriculum for emerging leaders of various racial and cultural backgrounds to advance BHCS goals toward building a more equitable, culturally responsive, trauma and racially informed workforce and leadership. The contract term will be from March 1, 2019 to June 30, 2020.

(Continued…Training and Technical Assistance)

FY 19/20 Anticipated Changes:

- The Alameda County General Services Agency posted a Request for Proposals with the intention to contract with a vendor to provide, implement, host, train, support, and maintain a cloud-based Learning Management System (LMS). This new LMS will provide a data management system for self-registration and tracking of instructor-led training, online, informal, and social learning which supports career growth and development. The County intends to award an initial three year contract, starting December 1, 2018, with an option to renew.

4. Internship Program

Program Description: Coordinates academic internship programs across the ACBHCS workforce. Meets with educational institutions to publicize internship opportunities and provides training to Internship Programs.

FY 17/18 outcomes/impacts/and challenges:

- Facilitated and scheduled 22 trainings for graduate student interns.
- Offered training to nine graduate student interns on Co-Learning, Mindfulness Training, Motivational Interviewing, Trauma Informed Care etc.
- In collaboration with the county counsel, facilitated and processed Practicum Agreement for the University of Southern California (USC) – Online MSW program.
- Created in collaboration with the MHSA Prevention and Early Intervention Coordinator (PEI) and Clinical Intern Supervisors, a new post-evaluation for continuous evaluation of the effectiveness of the intern program.
- BHCS Graduate Intern Stipend Program:
    - Launched and administered the 6th cycle of the stipend program in August 2017 with a focus on interns across system.
    - Awarded 36 stipends in the amount of $6,000 for 720 internship hours. Of the 36 awardees, 65% represent the diverse communities of Alameda County.

FY 18/19 Progress Report:

- Developing a system for collecting and managing clinical intern training evaluations, in order to identify how to best meet the needs of the programs hosting interns.
- Conduct outreach to ethnic organizations to improve diversity of the graduate intern applicants, therefore, increasing the approved pool of graduate interns.
- Developing internship opportunities with BHCS Vocational Rehabilitation and the Office of the Medical Director; and re-launching internship programs with Conditional Release Program (CONREP) and the Adult System of Care (ASOC).
- Continue to provide onboarding support to all interns.
- Launched 7th cycle of Graduate Intern Stipend Program in August 2018 with a focus on interns across system, including behavioral health interns in primary care settings and a focal point on threshold languages: Spanish, Cantonese, Mandarin, Vietnamese and Tagalog.

FY 19/20 Anticipated Changes:

- BHCS WET does not anticipate any significant program implementation changes during FY 19-20.

D. WORKFORCE, EDUCATION & TRAINING (WET) PROGRAM SUMMARIES

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 17/18 Outcomes, Impact & Challenges:

BHCS has developed and implemented the following activities:

- WET in collaboration with Alameda County Health Care Services Agency (HCSA) provided Summer Career Exploration program to high school students from diverse racial, immigration, cultural and economic backgrounds. 2017 Summer Career Exploration program consisted of five (5) week experiential project-based learning opportunity and college and career exploration. 23 tenth and eleventh grade students were exposed to a variety of health careers and opportunities
- BHCS WET collaborated with the BHCS Pool of Consumer Champions (POCC) and Merritt College Medical Assistant program to administer and implement a pilot program that provides education and training to a cohort of four mental health consumers who will receive certification as a Medical Assistant followed up by placement in a primary care facility such as a Federal Qualified Health Center (FQHC) or another facility designated by Merritt College.
- Bright Young Minds (BYM) is a one-day, highly intensive day of structured activities for high schools that introduces students to careers in behavioral health. Planned, organized, and co-hosted the Bright Young Minds (BYM) conference on March 26, 2018 at the University of California at Berkeley, in collaboration with Alameda County Health Pipeline Partnership (ACHPP), and Oakland Unified School District (OUSD). It was a ground-breaking conference and 130 high school students from diverse and under-represented communities participated to explore behavioral health care career options.
- Berkeley City College continued to teach wellness, recovery and resiliency focused curriculum- Introduction to Behavioral Health (HUSV 117) which was developed and written by BHCS.

FY 18/19 Progress Report

- Alameda County Behavioral Health Care Services (BHCS) hosted 9 high school students from June 18 through July 19 for 40 hours/week. At BHCS, the students were paired with intern preceptors/mentors for 20 hours/week, and given project based learning opportunities such as: learning to network, communicate and dress professionally, presentation skills, resume building, attending stakeholder and/or staff meetings, research and program evaluation, contracting procedures, and creating a resource guide for the Mental Health Service Act website. By doing work in an office setting, students gained valuable insight from an administrative perspective about key program development elements such as planning, coordination, team work and continuous quality improvement.
- High School interns spent 20 hours/week in the classroom sessions to gain foundational learning about behavioral health concepts, and to explore and gain tools about their own health and wellness strategies. Classroom topics included: Mental Health 101, College prep and Career Pathways in mental health, recognizing and balancing life's stressors between school and home, participating in a healing circle, Trauma-Informed Care, and becoming a trained and certified Youth Mental Health First Aider.

D. WORKFORCE, EDUCATION & TRAINING (WET) PROGRAM SUMMARIES

(Continued… Educational Pathways; FY 18/19 Progress Report)

- High School interns also attended site visits once a week in order to see the multi-faceted breadth of services, and individuals and groups who are supported and served within Behavioral Healthcare. To mention a few, interns went to: Family Education Resource Center (FERC), Vocational Services, and the Behavioral Health Courthouse. All of these field--based learning opportunities really bonded the group together and gave them insight about what it takes to administer behavior health care services for the public, all with a wellness and recovery focus.
- BHCS WET as a Bay Area Mental Health and Education Workforce Collaborative partner coordinated and co-hosted a Mental Health First Aid Instructors training to a cohort of twenty five people. This training was planned and offered in response to meet community capacity building requests to teach others how to respond to mental health needs with young people. Participants consisted of Oakland Unified School District (OUSD) teachers and BHCS community providers and staff. Twenty five people became certified as instructors and with these additional instructors, the WET Training unit plans to provide Youth MHFA trainings to high school teachers, BHCS and contracted provider staff, and community groups.
- Provided advanced training in "primary care psychiatry" to ten primary care providers in collaboration with the UC Davis Train New Trainers (TNT) Primary Care Psychiatric Fellowship Program. There were 10 Fellows in Calendar Year 2017, and 10 have enrolled in the 2018 Fellowship Program. All of the Alameda County, Primary Care Fellows are from the FQHCs that serve the AC Care connect population;
- Provided clinical education and experience to one selected UCSF Psychiatric Fellow in 2017 at the BHCS Trust Clinic and the trainee/fellow has been hired to work as a staff Psychiatrist at the Trust Clinic. Currently providing clinical education and training to one UCSF Psychiatric Fellow at the Trust Clinic.
- With funding support from BHCS WET, La Clinica de la Raza developed and started a Psychiatric Residency Rotation in collaboration with the psychiatric training program at Stanford University and the University of California at San Francisco (UCSF) School of Nursing. La Clinica provided clinical training and supervision to one psychiatry resident and a registered nurse practitioner (RN) who are bi-lingual in Spanish. Both trainees are now fully integrated into La Clinica treatment teams and working with clients at the same time receiving training and supervision. La Clinica used the seed money provided by WET in developing systematic efforts to address shortages in the psychiatric workforce in public mental health. Additionally, La Clinica was able to utilize Psychiatric Residency Rotation Program's clinical supervisor's time and resident training experience to develop the Office of the Statewide Health Planning and Development (OSHPD) Retention Grant application for which La Clinica is a sub-grantee. We anticipate that eventually BHCS Trust Clinic will be used as a training site for this program.
- MHSA WET provided funding to launch a new two year *Infant & Early Childhood Mental Health Postgraduate Certificate Program* at Cal State University, East Bay. The overarching goal is to build capacity in a culturally diverse early childhood mental health needs of young children and families in Alameda County. Year one is developmental foundations of infant and early childhood mental health with an emphasis on theory. Year two is developmental foundations of relationship based clinical work with infants, young children, families and caregivers. The curriculum has a strong emphasis on working with families from diverse cultural, racial and ethnic backgrounds. This is especially important as Alameda County is exceptionally diverse in terms of socio-economic status, race, culture, ethnicity, and immigration experiences.

(Continued…Educational Pathways; FY 18/19 Progress Report)

- In collaboration with the Oakland Unified School District (OUSD) and the FACES for the Future, BHCS WET is planning to co-host the seventh Bright Young Minds (BYM) conference in April, 2019 to expose and encourage economically and educationally disadvantaged and or underrepresented high school students to pursue careers in behavioral health.
- Collaborated with Chabot Community College to provide education activities related to introducing students to careers in Behavioral Health Care. Over 60 students from diverse ethnic and under-represented communities participated in exploring behavioral health care career options.
- 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 and help build the field based internship program.
- Continue providing presentations as requested to local high school students on Mental Health 101 and on introducing high school students to behavioral health career.

FY 19/20 Anticipated Changes:

- BHCS WET does not anticipate any significant program implementation changes during FY 19-20.

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 17/18 Outcomes, Impact & Challenges:

BHCS has developed and implemented the following activities:

- WET continued to provide Financial Incentives to eligible graduate interns placed in BHCS and contracted community-based organizations, and who are linguistically and culturally able to serve the underserved and unserved populations of the County.
    - Launched and administered the 6th cycle of the stipend program in August 2017 with a focus on interns across system.
    - Awarded 36 stipends in the amount of $6,000 for 720 internship hours. Of the 36 awardees, 65% represent the diverse communities of Alameda County.
- BHCS WET has partnered with OSHPD to implement the State Mental Health Loan Assumption Program (MHLAP).
- WET 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.
- Provided two MHLAP technical assistance application workshops to county and CBO staff and employment verification support to applicants and serve as the liaison between applicants and State MHLAP staff.
- 43 clinicians in County and contract Community Based Organization (CBO) settings received up to $10,000 towards their outstanding student loans.

D. WORKFORCE, EDUCATION & TRAINING (WET) PROGRAM SUMMARIES

(Continued…Financial Incentives Program; FY 17/18 Outcomes, Impact & Challenges)

- 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.

FY 18/19 Progress Report:

- Conducted a workforce employment retention survey among Alameda County MHLAP awardees from FY2010/11 – 2017/18 cycles. The purpose of the survey was to measure behavioral health employment retention within Alameda County BHCS of "hard to fill/retain" clinical positions, and measure if MHLAP's financial incentive program was able to increase diversity and language capacity within our services.
- Of the 216 awardees, 48% responded. Of those, 85% are currently working in Alameda County. Awardees represent the ethnic and linguistic diversity within Alameda County. The data indicated that 85% of the awardees have been retained and are providing services within Alameda County, 11% of those have moved positions within their organizations serving same population and 14% have gone to work for other organizations still within the county. About 12% are employed outside Alameda County, and less than 4% are currently unemployed.
- 61% of the awardees have been working in their positions for more than three years, 18% have been working in their position for three years, 12% for two years, and 10% for one year.

FY 19/20 Anticipated Changes:

- With eight years' experience gained from participating in the State-funded Mental Health Loan Assumption Program (MHLAP), BHCS is currently developing a local Loan repayment program, the "Alameda County Loan Repayment Program" (ACLRP), *modeled after MHLAP, t*o address the current service gaps and to provide financial incentive to hire and retain qualified, eligible employees in "hard to fill/retain" positions in Alameda County's Behavioral Health Care System. The State MHLAP, a financial incentive program, was available to eligible Alameda County applicants from FY 2010 until MHSA state funding ended on June 30, 2018. With the termination of State funding there are limited loan repayment program opportunities available to staff who are working with our underserved populations. It is urgent for us to take necessary actions to bridge the gap and continue addressing staff retention issues. There is a substantial shortage of qualified and diverse mental/behavioral health professionals and the lack of a financial incentive program such as MHLAP may result in staff leaving community mental health employment and securing higher paying positions in another county, or private organizations.
- BHCS Workforce Needs Assessment Survey results clearly showed evidence in favor of creating our own loan repayment program. In Nov 2017, the BHCS Workforce Needs Assessment Survey identified the following top five hard-to-fill and hard-to-retain positions: Licensed Clinical Social Worker, Psychiatrist Child/Adolescent, Licensed Marriage and Family Therapists, Psychiatric Mental Health Nurse Practitioner and Substance Use Disorder Counselor. Additionally, our system needs more bilingual staff in threshold languages such as Spanish, Cantonese, Mandarin, Vietnamese, and Tagalog. There is also a large need for staff who represent the client culture, such as: African-American, Asian Pacific Islander, Hispanic, Native American, South or Southeast Asian, LGBTIQQ2-S, and those with lived experience as a mental health consumer/family member.

E. CAPITAL FACILITIES & TECHNOLOGY (CFTN) PROGRAM SUMMARIES

Capital Facilities & Technological Needs (CFTN)

The Capital Facilities & Technological Needs (CFTN) component of the MHSA "works towards the creation of a facility that is used for the delivery of MHSA services to mental health clients and their families or for administrative offices. Funds may also be used to support an increase in peer-support and consumer-run facilities, development of community-based settings, and the development of a technological infrastructure for the mental health system to facilitate the highest quality and cost-effective services and supports for clients and their families".

NEW Capital Facilities & Technology (CFTN) Projects

Through our Community Input process in FY 17/18 the areas of housing, homelessness and the availability of crisis services (to reduce/prevent hospitalizations) were top concerns reported by local residents. BHCS is aligned with these issues and is developing a multi-prong approach to improve crisis access as well as partner with the community to reduce homelessness for individuals with severe mental illness. It should also be noted that BHCS' MHSA funded Capital Facilities projects are in alignment with Alameda County's Vision 2026. More on this vision can be seen at https://vision2026.acgov.org/index.page

During FY 18/19 the following CFTN projects will be developed. Some projects will be completed in FY 18/19 and others will continue through FY 19/20.

Land Purchase: BHCS has used its AB 114 CFTN funds to purchase a small plot of land next to the A Street Shelter, this has been documented in a Board letter titled, the purchase of "real property at 22385 Sonoma Street, Hayward".

BHCS has been operating the A Street Homeless Shelter in Hayward since 1988. The subject lot is located at 22385 Sonoma Street immediately adjacent to the existing A Street Shelter. The approximately 6,250 square feet unimproved lot is vacant. BHCS plans to use the lot as additional parking, providing approximately 20 additional spaces to augment the inadequate parking capacity needed to serve employees, residents, visitors and service vehicles. This land may be augmented in the future to expand the A Street Shelter capacity.

Investment in permanent supportive housing and medical/psychiatric respite for Older Adults who are homeless: On July 10, 2018, the Alameda County Board of Supervisors declared a shelter crisis in our County upon a finding that a significant number of persons within the County are without the ability to obtain shelter and that the situation has resulted in a threat to the health and safety of those persons. The Health Care Services Agency (HCSA) seeks strategies to address the crisis, understanding that medically frail and aging homeless individuals face exposure and trauma, worsening conditions, premature mortality and risk dying alone on the streets.

BHCS, as part of HCSA, is in alignment with HCSA's vision of developing multiple strategies to reduce homelessness. To this point, BHCS will utilize AB 114 CFTN funds to invest in a project through the Alameda Point Collaborative to provide start-up funding for a development that will provide permanent

supportive housing, medical respite and extended care to people experiencing homelessness, with an emphasis on medically frail and individuals with complex medical and psychiatric needs. APC has initiated the development of a Senior Housing and Medical Respite Center (Center) to help alleviate the homelessness crisis and address adverse health outcomes among vulnerable populations in Alameda County.

The project will renovate and adaptively re-use the five existing buildings at the site, located on McKay Avenue next to Crab Cove in Alameda. The Center will provide the following programs:

- 90 units "Assisted Living" – permanent supportive housing
- 38-bed Medical Respite program
- 12-bed Extended Care
- Federally Qualified Health Clinic (FQHC)
- Coordinated Entry Service Hub
- Resource Center and Drop-In Center

Investment in facility development for the Berkeley Wellness Center: Alameda County, BHCS and the City of Berkeley have agreed to jointly develop a Wellness Center for the City of Berkeley in order to serve north county residents who have a mental health diagnosis or have experienced mental health challenges who will benefit from a cohesive set of wellness and recovery services. BHCS will dedicate AB 114 CFTN funds to develop this facility.

Investment in the final construction stages of the new dual crisis stabilization unit (CSU) and crisis residential treatment (CRT) program located in North Oakland: The State of California, through Senate Bill (SB) 82: Investment in Mental Health Wellness Act of 2013, allows counties to apply for grant funds for the purpose of expanding crisis services and facilities. Alameda County has been awarded grant funds under SB82 to develop a 14-bed crisis residential treatment program operating in tandem with a 12-bed crisis stabilization program. BHCS has, with County Board authorization, partnered with the local community-based mental health provider, Bay Area Community Services (BACS), to utilize these grant funds by developing a facility named Amber House in Oakland. BHCS is currently working with the General Services Agency (GSA) to determine a final timeline, construction deliverables and costs. MHSA funds will be used to leverage the final construction costs.

It's anticipated that the development of a CSU/CRT program will significantly reduce overcrowding at John George and reduce the impact on the emergency department of local hospitals while providing more accessible services to the residents of Alameda County. This increase supports BHCS's ultimate goal of expanding the County's number of beds at facilities throughout Alameda County.

E. CAPITAL FACILITIES & TECHNOLOGY (CFTN) PROGRAM SUMMARIES

Ongoing CFTN Projects

Project Name: South County Homeless Project (SCHP)

Project Description

The South County Homeless Project (SCHP) emergency shelter provides 24 shelter beds for men and women with serious mental illness currently experiencing homelessness. The shelter operates out of a county-owned property located at 259 A Street in Hayward and has not received any significant maintenance or upgrade work since it was first used for this purpose in 1989.

FY 17/18 Progress: At the request of BHCS with BHCS financing, the Alameda County General Services Agency (GSA) completed an assessment of the property and identified some key areas in need of repairs including the Heating, Ventilation, and Air Conditioning (HVAC) systems, electrical, plumbing, fire safety and prevention systems, and other areas identified in their report. The proposed repairs are in process and expect to be completed by June 30, 2018.

Program Name: MHSA Technology Project

Program Description

Purchase, installation and maintenance of a new Behavioral Health Management Information System, to include: billing, managed care, e-prescribing functions, data interoperability and functions as needed to support clinical and fiscal operations of BHCS. Additional expenditures for the necessary support staff during the implementation process, and other projects that provide access to consumers and family members to their personal health information and other wellness and recovery supports.

FY 17/18 Progress: BHCS continues its search and process of identifying a new Behavioral Health Management Information System. More information will be shared as it's available. Additionally under the MHSA Technology Project BHCS has been utilizing CFTN funds for the following items that have assisted BHCS in being more efficient and effective with utilization and outcome data:

- Behavioral Health Management Contracting System (to assist with the contracting process)
- Web-based dashboard System, called YellowFin
- Computer/Technology Technical Assistance
- Electronic File Storage and Document Imaging
- Clinician's Gateway Interface
- County Equipment and Software Update
- CFTN Administration

It should also be noted that CFTN funding was originally a 10 year block grant, which ended on June 30, 2017. However, through Assembly Bill (AB) AB 114, BHCS was given a grace period to utilize previously

reverted MHSA funding through June 30, 2020; of which BHCS has 7,530,171 in CFTN funds. For more information on BHCS' spending plan for AB 114 funds, please see BHCS' AB 114 Plan at https://acmhsa.org/reports-data/#mhsa-plans

After 2020 BHCS will need to access CSS funds to fund CFTN projects, i.e. Pursuant to Welfare and Institutions Code Section 5892(b), Counties may use a portion of their CSS funds for WET, CFTN, and the Local Prudent Reserve. The total amount of CSS funding used for this purpose shall not exceed 20% of the total average amount of funds allocated to that County for the previous five years.

INNOVATIVE PROJECT PLAN DESCRIPTION

County: **Alameda**	Date Submitted: **Dec 6, 2018**
Project Name: **Supportive Housing Community Land Alliance**	
Total Amount Requested: **$6,171,599**	
Duration of Project: **5 years**	

Executive Summary

Program Summary

Alameda County has been in search of innovative solutions that address affordable supportive housing for individuals with serious mental illness (SMI) because current solutions are not effective due to a housing crisis that continues to escalate and significantly affect this very vulnerable population. The County has been experiencing a decline in available housing units since 2004. During 2015-2017 alone, homelessness grew by 40%. Of these individuals who became homeless, 41% reported a psychiatric or emotional condition impacted their ability to obtain housing. This already dire situation has been recently exacerbated by the Northern California fires in Sonoma, Napa and Butte County.

Stable housing provides the foundation upon which people build their lives. Without a safe, affordable place to live, it's almost impossible to achieve good health or to achieve one's full potential. For people living with an SMI, stable and supportive housing not only has the potential to improve mental health, but also physical health, both of which help to increase overall quality of life and wellbeing.

The County is proposing to use a **community land trust model** to bring permanent affordability and community control to help ease its housing crisis for SMI consumers whose income is 200% of the federal poverty level.

A community land trust is a nonprofit formed to hold title to land to preserve its long-term availability for affordable housing. The trust retains ownership of the land and the homebuyer pays a lease fee on the land, which protects the trust's investment in the land. With land costs often being 30 to 40 percent of the price of a home, this model allows a buyer to afford a home by only borrowing on the structure. The homeowner can sell the property and make a small profit and recover the down payment, some equity and the cost of improvements. The trust keeps the rest of the money to provide for future buyers. This setup not only fosters pride of ownership and community, it provides an opportunity to move restrictive supportive housing approaches into the private sector for the public good.

Using innovation funds, a nonprofit community land trust entity will be created, which we've named, the **Alameda County Supportive Housing Community Land Alliance (CLA)**. The CLA will be developed by an agency chosen through Alameda County's public request for proposal (RFP) procurement process. The agency chosen will develop an organizing committee, Project Management Team, (PMT); Community Land Trust consultant; a Board of Directors (identified after the PMT is established) comprised of one-third each mental health consumers, family members, and public sector representatives; and legal counsel.

The CLA will be charged with not only creating the community land trust, but also developing housing guidelines, and best practices for board and care operations. Additionally, the CLA will launch an open membership structure within the CLA that provides community members with a means to participate in supporting the goals of the program.

Alameda County is aware that innovation funds *cannot* be used for the purchase of property or rehabilitation and/or construction of new housing. BHCS' Finance Department will have a fiscal tracking mechanism to specifically monitor these funds to ensure Innovation funding is appropriately being utilized under CCR§ 3910.010(b)(1).

Innovative Components

The Innovation component of the Mental Health Services Act provides counties the "opportunity to develop and test new, unproven mental health models with the potential to become tomorrow's best practices."[1] Alameda's proposed Innovation project's primary purpose is to increase access to mental health services through permanent supportive housing by using a community land trust model. This model has never been developed to house individuals with a serious mental illness, and if successful, has the potential to become part of tomorrow's best practices as it's shared with other counties. Moreover, this pilot project is testing the innovative ideas of the CLA being able sustain and fund itself through its fiscal modeling, and using rental fees to afford additional housing units.

What Success Will Look Like

The lack of affordable supportive housing does not provide individuals with SMI the opportunity for long term mental health support and recovery. Success of this model may bridge a current gap in services where homeless individuals receiving mental health care are more likely to continue to be homeless upon discharge or may not be able to continue mental health services due to not having stable housing. With this model, the individual's home is permanent, versus the current model of being assigned after discharge to what is available and potentially temporary. Having a *safe* and *secure* place to live is a vital part of wellness and recovery.

Success in the short term will include, but not limited to:

- Incorporating the community land trust (CLA) as a 501(c)(3);
- Forming a Board of Directors and staffing structure that allows for equitable participation by mental health consumers and family members, and
- Development of financing models that will sustain the operation of the CLA.

Long Term success will include, but not limited to:

- Effect on board and care closures, and
- The financial model is sustainable with funds being directed towards the development of new units.

[1] http://www.mhsoac.ca.gov/innovation-0

I. Innovations Regulations Requirement Categories

1) General Requirement

The proposed project applies a promising community driven practice or approach that has been successful in a non-metal health context or setting to the mental health system.

2) Primary Purpose

The proposed project increases access to mental health services, including but not limited to, services provided through permanent supportive housing.

II. Project Overview

1) Primary Problem

The need for affordable supportive housing for individuals with a severe mental illness continues to increase in Alameda County as traditional approaches to the problem have not been effective due to a housing crisis that continues to escalate and significantly affect this very vulnerable population. It should also be noted that while the Bay Area has been in a housing crisis for several years now, the recent Northern California fires in Sonoma, Napa and Butte County have drastically increased this crisis to an even more alarming and dire rate.

Across the Bay Area, an inadequate supply of housing stock, particularly affordable housing, has contributed to rising home prices, rental rates, evictions, displacement and homelessness. Households living on fixed incomes such as seniors and people with disabilities, including individuals with severe mental illness, face the most significant challenges in maintaining a home in this environment. In the Bay Area, there are only an estimated 25 affordable housing units for every 100 extremely low-income households. Housing and Urban Development (HUD) Fair Market Rents for one-bedroom apartment units grew by 71% between 2013 and 2018. Conversely, Supplemental Security Income (SSI) payments for disabled individuals in 2018 cover *less than half* of the rent of a one-bedroom at the 2018 Fair Market Rate in Alameda County. The County requires approximately 54,000 more affordable rental homes to meet current demand. This housing landscape has had a devastating impact on individuals and families impacted by serious mental illness.

In 2006, Alameda County issued a 15-year plan to address homelessness and the housing needs of people with special needs including those with mental illness. This plan called for the creation of an additional 15,000 affordable supportive housing units by 2020. To date, an estimated 1,500 new supportive housing units have been created, *far below the pace needed to meet the goal.* While some supportive housing units have been created, Alameda County has also experienced significant declines in the number of licensed board and cares, residential hotels, and room and board facilities frequently utilized by individuals with serious mental illness.

Between 2004 and 2015, Oakland experienced a nearly 55% decline in the number of available residential hotel units from 2,237 to 1,224 rooms. Alameda County Behavioral Health Care Services (BHCS) Housing Services Office identified 50 room and board or independent living facilities utilized by

individuals with serious mental illness that had either been sold or closed displacing an estimated 500 individuals within a three year period (2014 and 2017). During the same time period, BHCS has lost over 80 licensed board and care beds previously occupied by people with serious mental illness. Inadequate supportive housing unit creation coupled with declines in shared housing options of last resort for seniors and people with disabilities have contributed to steep increases in homelessness and housing instability among people with serious mental illness. Between 2015 and 2017, the number of people experiencing homelessness at a point-in-time grew by nearly 40%; of these individuals who became homeless, 41% reported a psychiatric or emotional condition impacted their ability to obtain housing or employment. In FY2014-15, 6% of BHCS clients were homeless upon entry into services and 5% were homeless upon discharge. In FY2017-18 that rose to 9% on admission and 10% on discharge. The situation is dire.

The federal Substance Abuse and Mental Health Services Administration (SAMHSA) identifies "home" as an essential domain for a life in recovery.[2] Alameda County's current housing and services landscape makes obtaining and maintaining a "home" extremely challenging for individuals struggling with a serious mental illness. Innovative approaches that help create new supportive housing units and that minimize the loss of shared housing options are urgently needed.

Traditional affordable housing financing approaches remain time-consuming and costly when compared to private housing market strategies. A typical Bay Area affordable housing project can take 3-5 years to gather appropriate financing, approvals, and complete construction. Available properties frequently get acquired by private entities before affordable housing developers can even secure initial funding. The major federal and state sources of affordable housing financing often have rules that preclude the blending of market rate and affordable housing units in a single project. In addition, these sources create priorities that make financing smaller projects non-competitive. Publicly financed affordable housing projects also typically preclude family members from investing and securing a supportive housing unit for a loved one with a disability. Innovative approaches to address these traditional housing financing models and identifying ways to target and reduce these barriers are vital to shore up the housing gaps.

Given the critical nature of "home" for recovery and the worsening housing crisis in the Bay Area, several members of East Bay National Alliance for the Mentally Ill (NAMI) chapter created a supportive housing workgroup to investigate ways in which family members could support, advocate for, and invest in the creation of quality supportive housing for their loved ones. Many family members in this workgroup expressed a willingness to invest in a housing project if their investment could result in a guaranteed place for their loved one to live. Traditional affordable housing financing strategies do not allow for consumer/client ownership of their housing. In addition to this workgroup, Alameda County's recent Community Planning Process (CPP) identified homelessness as the top priority for adults and older adults, and the third priority issue for children, youth, and transition age youth.

Through its original MHSA housing funds, Alameda has developed 175 units within 25 MHSA housing projects across the County. These units serve all age groups (depending on the development) with subsidies included with multiple units. Even though Alameda is proud of these successful property projects it's only a "drop in the bucket" of what's truly needed.

[2] https://www.samhsa.gov/recovery

2) The Proposed Project

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

The Supportive Housing Community Land Alliance pilot project will promote interagency and community collaboration among BHCS, family members, consumers, and affordable housing developers to create a Community Land Alliance using a community land trust model to preserve and create affordable supportive housing units for BHCS clients. A community land trust is a nonprofit organization formed to hold title to land to preserve its long-term availability for affordable housing. The homes are sold to lower-income families. The community land trust:

- Retains ownership of the land and provides long-term lease, generally a ground lease, of the structure(s) to homebuyers;
- Maintains an interest in maintenance of the structures and property while tenant/co-owner makes improvements to the property;
- Retains a long-term option to repurchase the homes at an agreed-upon formula-driven price giving the *homeowner partial equity* with the remaining equity staying with the community land trust; and
- The structure is re-sold below-market rate and the cost of the land is retained in perpetuity within the trust.

Supportive housing property and subsidy management refers to creating an organization with expertise in direct and third-party property management and master leasing of supportive housing units coupled with expertise in managing long-term rental assistance/ housing subsidy funding from programs such as Section 8, MHSA, and HUD Continuum of Care grants.

Innovation funding will be used over five years to create and fully develop a non-profit Supportive Housing Community Land Alliance based on a community land trust and supportive housing model. The first two years will be used to create initial infrastructure, staffing, establish agreements between community partners, and develop policies and procedures.

The proposed community land trust will operate under the auspices of a board of directors comprised of 9-12 individuals with one-third consumers and family member representatives, one-third public sector representatives, and one-third community partners with specific areas of expertise and a commitment to expanding and improving supportive housing in Alameda County.

This community land trust model is designed to balance the interest of individual land trust homeowners with the interests of the community as a whole. The rationale for this structure is based on the recognition that all land trust residents have a common interest in the organization that owns the land the residents live on and also have a degree of control over that organization. The community land trust model fosters homeownership versus giving subsidies which solely aid initial recipients and leaves the County expending more resources in the future.

The Community Land Alliance, which will be developed by an agency chosen through the County's Request for Proposal (RFP) procurement process, will establish an organizing committee called the "Project Management Team", who will be responsible to:

- Draft and outline membership of the board of directors;
- Recruit board members;
- Identify an executive director;
- Develop CLA Advisory Committee to the board of directors comprised of a diverse membership including, but not limited to, the project management team, MHSA Stakeholders, interested community members, NAMI members, consumers, and family members; and
- Acquire legal counsel who will draft documents necessary to create a 501(c)(3) non-profit corporate structure; along with documents that will include, but not be limited to, articles of incorporation, bylaws, and application for federal tax-exemption.

The County has identified MHSA Capital Facilities and Technological Needs (CFTN) funding to purchase initial property for the pilot project, once the Community Land Alliance is up and running. The funding has been secured separately because MHSA Innovation funds are not permitted to be utilized for the purchase of land as Innovation funds cannot be used for projects exceeding five (5) years as specified in CCR§ 3910.010(b)(1).

The BHCS' Finance Department will have a fiscal tracking mechanism to specifically monitor and track these Innovation funds to ensure Innovation funding is not used for the purchase of property or rehabilitation and/or construction of new housing. In BHCS, each MHSA component has a unique organization and program number that's attached to all projects so that Finance staff can accurately track appropriation and spending by component area. This is BHCS' standard practice in order correctly document expenditures on the MHSA Annual Revenue and Expenditure Report.

Further funding will be sought to continue operation of the project from other sources such as No Place Like Home, tax credits, or alternative sources identified by the Supportive Housing Community Land Alliance.

The Supportive Housing Community Land Alliance is expected to increase the ability to secure and maintain affordable supportive housing for clients living with a severe mental illness by:

- Leveraging public and private investments in a single property. Examples include family member and client ownership, mixed affordable and market rate developments, and cross-subsidization with condominium developments where some units are purchased at market rate, and the remaining will be less than market rate for affordability for BHCS' clients;
- Building an organization with supportive housing property management skills, master leasing capacity, housing partnership, and the subsidy management expertise necessary to secure housing units for BHCS consumers when opportunities arise;
- Using a non-profit 501(c)(3) structure to preserve the use of land and associated structures for sustaining supported housing units for people with histories of serious mental illness.
- Developing financial and operational models, and best practices for acquiring, rehabilitating, and managing licensed board and care and independent living shared housing facilities;

- Utilizing publicly-funded rental subsidies in creative ways to expand opportunities for those with rental subsidies, to create opportunities for tenant ownership, and/or reinvestment of subsidy funds into expanding supportive housing unit availability;
- Provide ongoing stewardship to the clients and property co-owners while they own their homes and manage resales to ensure the home or property stays affordable to subsequent buyers.

The primary staffing of the Community Land Alliance and their roles will include:

- BHCS Project Manager: The BHCS Housing Services Office Director will supervise a Project Management consultant to oversee the implementation of the Innovation project, such as developing agency and community support and linkages, developing the initial Request for Proposal (RFP) model for project launch, ensuring the project achieves its intended innovation objectives, and coordinated project evaluation and reporting to stakeholders.

- Community Land Alliance Executive Director: Provide primary oversight of the Community Land Alliance, consultants, and staff; development of a Community Land Trust Board of Directors and By-Laws, financing models, family investment model, and sustainability model; cultivating housing projects.

- Property Management Director : Supportive housing property management policies and practices will need to be developed that integrate existing best practices and the unique requirements created by the mixed funding sources, such as family/client ownership. Management of supportive housing properties requires unique approaches, workflows, and staffing.

- Workforce Development and Training Director : Successful supportive housing projects require that staff members involved in specific projects clearly understand their role and responsibilities, have the supervision and support necessary to fulfill their roles, and have training, feedback, and skill development opportunities that enhance their work performance and job satisfaction. The workforce development and training coordinator will focus on ensuring staff involved with specific supportive housing projects have the supports and tools necessary to maximize the success of housing projects.

- Multiple consultant and contractors: BHCS will engage legal and professional consultants regarding community land trusts, affordable housing development, financing, and operating models.

Once established, the Community Land Alliance will utilize existing and planned financial and other resources to implement its key strategic aims. Examples of these resources include HUD Continuum of Care housing subsidies, MHSA Community Services and Supports (CSS) locally created housing subsidy funds, No Place Like Home MHSA bond funds, and a one-time set-aside of local MHSA Capital Facilities and Technological Needs funds for the Community Land Alliance initiated housing projects.

By developing a new model for securing and governing affordable supportive housing, we hope to assist other counties facing similar housing crises. The County's model, if successful, could not only reduce the learning curve for other counties who want to develop their own community land trust, but generate an *opportunity for larger statewide collaboration.*

A statewide collaboration could be developed by the California Mental Health Services Authority (CalMHSA) as it's a Joint Powers Authority governmental entity and its purpose is to serve as an independent administrative and fiscal structure for jointly developing, funding, and implementing mental health services. CalMHSA could be the fiscal manger and either play a similar role to the role of the California Housing Financing Authority (CalHFA) or enter into a coordinated agreement with CalHFA; *There are many possibilities and opportunities.*

CalMHSA is currently providing similar administration with the Innovation Technology Suite Project on behalf of participating member counties. CalMHSA has the capacity of resources, diversity, and collaborative orientation to lead the way in this dynamic delivery of supportive housing. If the County's model proves successful, CalMHSA could be a viable way to address homelessness for individuals living with severe mental illness and their family members within the entire state.

b) *Identify which of the three approaches specified in CCR, Title 9, Sect. 3910(a) the project will implement (introduces a practice or approach that is new to the overall mental health system; makes a change to an existing practice in the field of mental health; or applies to the mental health system a promising community-driven practice approach that has been successful in non-mental health contexts or settings).*

This proposal makes a change to an existing practice in the field of mental health through the development of new approaches to securing, governing, financing, and operating supportive housing units for people with serious mental illness.

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

This approach blends a variety of strategies utilized in other settings to address the needs of individuals with serious mental illness in a challenging housing market. As discussed in question 2, pages 4-6, each of the strategies being used has successfully addressed *some* aspect of the problem.

Community land trusts secure land and property for long-term affordability, create home and property ownership opportunities for low-income households, and provide ongoing stewardship of land for a defined public purpose.

Supportive housing property management and subsidy expertise has been utilized in other communities to master lease housing from private owners and to maximize the quality of supportive housing operations.

Continuing Care Retirement Communities (CCRC) provide models of tiering several levels of supportive care within a single property. In addition, some CCRCs highlight the possibility of combining market rate and affordable units within a single development.

The proposed Community Land Alliance creates an opportunity to *integrate these models* into an organization focused on the creation of quality supportive housing units for individuals struggling with a serious mental illness and their families.

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

Alameda County Behavioral Health Care clients will be directly served by this Innovation project. During the proposed five-year initial funding cycle, BHCS anticipates completing at least two new supportive housing projects through the new organizational infrastructure. One of the projects will incorporate a home ownership model for clients with serious mental illness and the other will utilize a land trust model to secure an independent living or licensed board and care home for individuals with serious mental illness. At least 10 BHCS clients will be served through these two housing projects. In addition, it's anticipated that over 200 BHCS clients will benefit from the organization's housing subsidy and property management skills and capacities over the five-year innovation cycle. These estimates come from initial plans to start with two smaller housing projects of 4-6 units in size plus the plan to coordinate supportive housing property and subsidy management for at least 200 of Alameda County's current supportive housing inventory of over 2,000 units.

Over the long-term, BHCS anticipates that this organizational model developed with Innovation funds will accelerate the creation and maintenance of supportive housing units within the County.

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

The target population includes adults with serious mental illness residing in Alameda County that are living with extremely low incomes. Participants' income is to be roughly 200% of the federal poverty level or below; on SSI and/or Medi-Cal; have been referred through BHCS' healthcare system; and are not receiving the care they need because of their housing needs. The population of Alameda County in 2017 was 1,663,190 residents, of which there's an estimated 4%, or 66,528, Alameda County residents who struggle with serious mental illness so the need for housing and supportive services in the County is high[3]

[3] http://www.dhcs.ca.gov/provgovpart/Documents/CaliforniaPrevalenceEstimates.pdf

3) Research on Innovative Component

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

While this project borrows from a number of models, it's innovative in the following ways:

- A community land trust model allows for more financing models that traditionally are used for creating affordable supportive housing.
  - It creates opportunities to secure properties for public use more quickly which can lead to an increase in preserving and developing housing projects.
  - It offers an opportunity to leverage private investment and an opportunity for cross-subsidization of supportive housing units with market rate units.
  - It allows for family members to invest in housing units for their adult children with serious mental illness.
  - A community land trust provides a mechanism to protect the public and private investment; this subsidy retention keeps the home affordable generation after generation without additional subsidy required to keep the home affordable at resale.
  - The community land trust model creates an opportunity to build community wealth, making the land a community asset in perpetuity and also creates an opportunity to build equity for the homeowner.

- A community land trust provides an opportunity for inclusion of people with serious mental illness and their families into leadership around developing, operating and maintaining housing.
  - Community land trusts have a history of benefitting disenfranchised populations; and
  - The flexibility of the community land trust model has nurtured a development of empowerment for its members.

- A community land trust allows for innovation, inclusive, and integrated forms of housing developments that are difficult to finance and operate within traditional affordable housing models.

- Expanding supportive housing models into non-traditional settings, such as a community land trust, allows for increasing the opportunity to provide support in affordable units.

b) *Describe the efforts made to investigate existing models or approaches close to what you're proposing.*

There are over 200 community land trusts in the United States. Most of these community land trusts vary from one another depending on their targeted community. The model's targeted population served affects the type and tenure of whatever housing is developed; amount of subsidy for affordability; type of funds available from governmental sources; design of the resale formula; marketing plan; selection criteria; and organizing strategy.

There are *no community land trust models whose targeted populations are individuals with severe mental illness.* However, there are programs that are using inventive ways for supportive housing through the collaborative efforts between the private market and a government agency:

- Brilliant Corners in Los Angeles, in cooperation with the Conrad N. Hilton Foundation, has launched a new supportive housing rental subsidy program called Flexible Housing Subsidy Pool. Their goal is to secure decent, safe, affordable housing for homeless DHS patients and have complex physical and behavioral health conditions. Tenants will be linked with wrap-around, intensive case management services to support them from transition to permanent housing. http://brilliantcorners.org/brilliant-solutions/housing-for-health/

- Seattle's Landlord Liaison Project, which currently is operated by King County, WA, is a collaborative partnership between property managers and service providers that helps people who can afford rent, but have barriers to accessing housing. https://kingcounty.gov/depts/community-human-services/housing/services/homeless-housing/landlord-liaison-project.aspx

Many of the current community land trusts have been in existence for 20 years or more. A number of community land trusts are in the Bay Area and along the West Coast. Executive Director, and founder of the Lopez Community Land Trust, Sandy Bishop; and Executive Director of the Housing Land Trust of Sonoma County, Devika Goetschius, are being consulted on an ongoing basis. https://www.lopezclt.org/staff/; https://housinglandtrust.org/. It must be noted that Ms. Goetschius is also a consultant for Burlington Associates, a national consulting cooperative who specializes in the development of community land trusts and other shared equity homeownership strategies. http://www.burlingtonassociates.com/#!/home

The controversy of affordable housing tends to trigger an immediate NIMBY ("Not in my backyard") response. Ironically, most communities would agree that affordable housing should be OKIMBY ("Okay in my backyard") if that housing contributed to the neighborhood and made it possible for stable families and individuals to live in the neighborhood. A common denominator for any affordable housing plan is effective communication among stakeholders which must exist for the plan to be successful[4].

The County's proposal is clear on who to serve and why. As part of this project, the County will be meeting with the surrounding communities and communicating with stakeholders. We believe the key is education and taking the time to provide information and receive feedback through various methods (in-person community meetings, emails, written comments, phone discussions, etc.).

4) Learning Goals / Project Aims

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

[4] (*Affordable Housing: Can Nimbyism Be Transformed into Okimbyism?, Peter W. Salsich, Jr., Saint Louis University Public Law Review, Vol 19:453, 2000*).

Alameda has four Learning Goals:

1. Can a community land trust model, targeting the SMI population, facilitate a successful financing model that results in adequate resources to sustain operation of a community land trust?

2. Can Alameda County within two years of using a community land trust model create an equitable representation on a well-run/effective Board of Directors (BOD) that includes one-third consumers, one-third family members, and one-third community housing experts?

3. Can the use of a community land trust model for supportive affordable housing targeted to the SMI population have an effect on board and care closure rates in Alameda County?

4. Can the community land trust model provide an opportunity to build personal wealth, balanced with community wealth using the private sector for public good?

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

The proposed learning goals match the intentions of the proposed community land trust innovation model.

Overall, Alameda is wanting to test the hypothesis that the traditional land trust model can be introduced into the behavioral health environment for the benefit of individuals with a severe mental illness and their family members.

By utilizing MHSA Innovation funds as "seed" funding to set up the proposed land trust we envision a sustainable entity, with equitable stakeholder representation, that in the long run utilizes non Innovation funds to create supported housing units. The stability from the supportive housing environment will ultimately increase access to mental health services and promote wellness and recovery.

5) *Evaluation or Learning Plan*

Specifically, please identify how each goal will be measured and the proposed data you intend on using.

- Can a community land trust model, targeting the SMI population, facilitate a successful, financing model that results in adequate resources to sustain operation of a community land trust?

Data to collect	Data collection method
• What funding types can this model attract and secure? (funding from foundations, healthcare, local/state revenue, MHSA, reinvestment of rental income, etc.)	• The land trust records including, but not limited to, grant proposal, contracts, rental, agreements, and loan documents. • The Project Coordinator will also track length of time and effort it takes to secure funds.

• Operating and Expense analysis	• Comparison and research of operating/expense costs between different fiscal models. • Various fiscal models that are developed

- Can Alameda County within two years of using a community land trust model create an equitable representation on a well-run/effective Board of Directors (BOD) that includes one-third consumers, one-third family members, and one-third community housing experts?

Data to collect	Data collection method
• Who participates on the BOD? • How often does the BOD meet? • What discussions and decisions are made and by whom that provide guidance to the project?	• The assistant to the BOD will collect membership rosters, sign-in sheets, meeting minutes, etc.
• BOD's perception of the effectiveness of the land trust, including what contributed to or impeded success. • "Effectiveness" will be operationalized as: well facilitated/structured meetings, opportunities for all voices to be heard, concrete decision making structure, terms of service for the BOD, clear/structured application process to become a BOD member, etc.	• Annual surveys, focus groups and/or key informant interviews with BOD members. • Application documents, decision-making documents, meeting minutes, and bylaws.

- Can the use of a community land trust model for supportive affordable housing targeted to SMI population have an effect on board and care closure rates in Alameda County?

Data to collect	Data collection method
Current assessment of board and care facilities in Alameda County: • # of facilities • Provider satisfaction with being a board and care operator • Training/resource needs of board and care operators • Other items the evaluation team will define	• As part of the evaluation of this project, the evaluation team will conduct a basic needs assessment to determine baseline information. this will include quantitative and qualitative methods (surveys, focus groups and/or key information interviews) internet search for sites, etc.

• Trainings/support offered to board and care operators on best practices and residents (on how to be a good resident/roommate)	• Training surveys, follow up surveys/interviews
Follow-up assessment of board and care facilities once the land trust model is up and running: • # of facilities • Provider satisfaction with being a board and care operator • Training/resource needs of board and care operators	• The evaluation team will conduct the follow-up needs assessment to determine change from baseline. This will include quantitative and qualitative methods (surveys, focus groups and/or key information interviews) internet search for sites, etc.

- Can the community land trust model provide an opportunity to build personal wealth, balanced with community wealth using the private sector for public good?

Data to collect	**Data collection method**
Does the financing model developed enable family/clients to purchase units, this will include: • Financing and legal structure for family ownership of housing for adult relatives.	• Consumer/family response to guidelines and process established. Survey of BHCS consumers/family members after the guidelines are drafted. • Gathering copies of written materials outlining proposed ownership method and associated legal issues.
• What investments from family members have been made in specific land trust projects?	• Copies of records of family investments in specific housing projects.
For clients who become stably housed as a result of the community land trust model: • Percent who have employment income • Percent of consumer's usage of acute mental health services after 1-year • Percent of consumers who have obtained health insurance after 1-year.	• SSI and income before and after being housed in a supportive housing unit facilitated through the community land trust • Comparison of acute services used before and 1-year after. Data will be obtained through the County Medi-Cal billing system or current EHR. • Comparison of consumers' having health insurance before and 1-year after. Data will be collected through interviews and/or County Medi-Cal billing system or current EHR.

Data collection, evaluation and reporting for this project will be in alignment with the current Innovation Regulations. This includes collecting indicated demographic data, tracking changes made to the project in the course of implementation, and providing annual and final reports covering all required elements.

Evaluation of this project will be contracted out. The evaluators will assist in finalizing the evaluation plan, developing the appropriate tools, gathering and analyzing the data, and vetting the evaluation plan and tools with appropriate stakeholders. They will document factors that might affect the outcomes and will attempt to increase the validity of the results.

III. Additional Information for Regulatory Requirements

1) Contracting

The implementation of this project will be led by the BHCS Housing Services Office Director. He will supervise a project manager hired to oversee and implement this project. After receiving approval from the Mental Health Services Oversight and Accountability Commission (MHSOAC) for the project, BHCS will conduct a Request for Proposal (RFP) process seeking an existing affordable housing developer and mental health service provider with an interest and commitment to creating a Supportive Housing Community Land Alliance. A review panel inclusive of family members, consumers, housing finance experts, service providers, and County staff will select the nonprofit partner(s) to help implement this proposed Innovation project.

2) Community Program Planning

The Community Planning Process (CPP) for the MHSA Three Year Plan was conducted from June – October 2017. During that process BHCS staff provided updates and information on current MHSA programs and community members provided input on mental health needs and services.

There were three modes for providing input:

- Five large community forums (one in each Supervisorial District);
- Eighteen focus groups were conducted throughout Alameda County: Chinese speaking family members, African American family members, providers for refugees, providers for LGBTQ community, transitional age youth (2), Afghan immigrants, older adults, API and refugee providers and advocates, providers for individuals with developmental disabilities and mental illness, and Pool of Consumer Champions (BHCS's mental health consumer group);
- Community Input Surveys in all threshold languages: submitted by 550 unique individuals. Respondents were very diverse in age, race, and ethnicity. Fifty percent of respondents were from Oakland, while they make up only 30% of Alameda's population. Survey respondents included: Mental health consumers (25%), family members (17%), community members (15%), education agency (2%), community mental health providers (14%), homeless/housing services (6%), County Behavioral Health staff (1%), faith-based organization (2%), substance abuse services provider (<1%), hospital/provider care (4%), law enforcement (1%), NAMI (1%), Veteran/Veteran services (1%), other community (Non-MH) service provider (5%), other/decline to state (9%).

Throughout the CPP housing and homelessness was a key theme:

- 72% of community respondents ranked homelessness as the number one issue for adult and older adults;
- 70% ranked homelessness as the number three issue for children/youth/transitional age youth, and
- 63% ranked "persons experiencing homeless" the top underserved population.

Moreover, when community members were asked open-ended questions about potential new Innovation project ideas they'd like to see planned and implemented 21% of respondents mentioned multiple areas around housing including: creating a land trust, purchasing property for more supportive housing, creating more board and cares, supporting and "cleaning up" existing board and care facilities, etc.

Other innovative project areas included new mobile crisis services, school-based services for children, more peer support programs, substance use (cannabis) education and culturally responsive programing; of which several of these topic areas have already been incorporated into other Innovation projects.

Details of the CPP are provided in the MHSA Three Year Plan (www.ACMHSA.org under Resources/MHSA Plans).

Based on the data from the CPP and public comment/input from the MHSA Stakeholder Committee, the BHCS Housing Department submitted a proposal framework to the BHCS Department. The proposed project was vetted by MHSA staff based on whether it addressed community priorities, as well as other factors such as MHSA Innovation criteria. . This project was approved for planning in late 2017 and was presented to the Alameda MHSA Stakeholder Committee at their December 2017 meeting for initial input. From there, BHCS worked on the proposal internally with additional input from BHCS staff, MHSOAC staff, and the Alameda County Social Services Agency, which may become a collaborative partner for this project once approved.

3) MHSA General Standards

a) Community Collaboration: This project includes clients, family members, and other stakeholders in the process of developing a community land trust and the governance structure of the community land trust.

b) Cultural Competency: This project will serve the diverse BHCS client population. While the model will include an option to purchase a housing unit, it's not necessary, so finances are not a barrier to who can be served. The supportive services provided will be governed by the same requirements all BHCS services are in terms of ensuring cultural competence of staff, reducing disparities in access, and cultural appropriateness of housing units and services.

c) Client-Driven: Clients will be included in the collaborative process of developing and the governance structure of the community land trust. This includes participating in developing policies, procedures, and the evaluation.

d) Family-Driven: Families will be included in the collaborative process of developing and the governance structure of the community land trust. This includes participating in developing policies, procedures, and the evaluation.

e) Wellness, Recovery, and Resilience-Focused: Supportive housing aims to house people in the least restrictive environment with the maximum amount of self-determination and self-responsibility. In addition, the community land trust model supports client empowerment through participation in the governance structure.

f) Integrated Service Experience for Clients and Families: Supportive housing aims to provide services "at-home" to increase access to services, as well as housing stability.

4) Cultural Competence and Stakeholder Involvement in Evaluation

*a) Explain how you plan to ensure that the Project evaluation is **culturally competent**.*

The evaluation of this project will aim to be culturally competent by including family members and consumers in the initial design and implementation of the project evaluation. This project intends to utilize a community-based participatory research approach that serves as a vehicle for ongoing improvement of the model and its effectiveness. The evaluation plan and tools will be discussed with BHCS' Cultural Responsiveness Committee.

b) *Explain how you plan to ensure **meaningful stakeholder participation** in the evaluation.*

Clients and family members will be part of the collaboration to develop the community land trust, including the development of the RFP process, evaluation of RFP proposals, seats on the CLA Advisory Committee as well as the governance structure of the community land trust. These bodies will participate in developing the evaluation, assisting to implement any tools such as satisfaction surveys, as well as analyzing and presenting the results.

5) Innovation Project Sustainability and Continuity of Care

a) Will individuals with serious mental illness receive services from the proposed project?

If the pilot project proves successful, BHCS will support the continuation of the project or components of the project based on a number of internal and external factors and processes including: 1) the evaluation results from the project, 2) recommendations from the MHSA Stakeholder Committee and 3) available funding. Ideally this project will result in a financial model that will allow for the sustainment of the operation of the Community Land Alliance as well as funding for future purchase and maintenance of properties.

As stated in *2) The Project Proposal, pages 5-9,* further funding will be sought for sustainability of the project through other funding sources. There is also continuing negotiations with several consumer family members, and private donors, interested in either donating property or purchasing housing through a community land trust if the pilot proves successful.

In addition to other funding sources BHCS will utilize the first several years of funding to develop and learn about various fiscal modeling tools to sustain the operation of the organization and to learn how to re-invest funding for future properties and land opportunities, these models include:

- Affordable Pricing and Resale Formula Design or Review
- Shared Equity Business Planning
- Fee and Revenue Analysis
- Shared Equity Program Adoption Analysis
- Integrating Lasting Affordability into Policies and Investments
- Market Research and Financial Feasibility Analysis
- Revenue Generation and Housing Trust Funds
- Co-Op/Shared Housing Programmatic and Fiscal Models
- Affordable Housing Preservation Strategies

6) Communication and Dissemination Plan

a) How do you plan to disseminate information to stakeholders within your County and (if applicable) to other counties?

The Project Coordinator will be responsible for developing updates and coordinating dissemination plans. Updates on the project will be provided to stakeholders on an ongoing basis via email and presentations at existing meetings. The CLA Advisory Committee will be responsible for disseminating updates and results to their agencies, other stakeholders, and other counties. The final evaluation report for this project will be shared widely by posting it on the BHCS website and announcements via email to stakeholders, including to mental health directors, mental health housing offices, supportive housing agencies, and MHSA coordinators throughout the state. In addition, presentations will be made by Advisory Committee members to the MHSA Stakeholder Group, the Alameda County Mental Health Board, the Cultural Responsiveness Committee, other consumer groups, NAMI, the Board of Supervisors, and affordable housing development stakeholder groups and conferences.

b) How will program participants or other stakeholders be involved in communication efforts?

The Advisory Committee members will share updates with their agencies and stakeholders, as well as participate in providing presentations to the organizations listed above. The project coordinator will be responsible for website postings, email announcements, and coordinating communication plans.

c) *KEYWORDS for search:*

Key words that were used in research for this innovation project were: supportive housing, Community Land Alliance; community land trust, housing crisis, mental health supportive housing; and mental health community land trust.

7) Timeline

a) Specify the expected start date and end date of your INN Project:
Start: July 2019 End: June 30, 2024

b) Specify the total timeframe (duration) of the INN Project? 5 years

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

Timeline	**Activities/Milestones**
July 2019	Preparation and release of RFP
September 2019	Selection of nonprofit partner(s) for land trust implementation
December 2019 – June 2020	Development and creation of Supportive Housing Alliance organization – recruitment of board members, finalize by-laws and governance charter, complete articles of incorporation and new legal entity, identify and hire executive director.
June 2020 – January 2021	Secure and establish work space for organization, establish nonprofit operational infrastructure, hire key leadership positions, develop supportive housing property management policies and procedures for differing housing models, develop workforce development and training plan, start financial modeling for first two housing projects. Secure MHSA one-time CFTN funding for first two housing projects.
November 2020 – January 2021	Develop master leasing and housing subsidy management policies and procedures, hire and train key staff to operationalize property and subsidy management plans, begin transition of property and subsidy management approach from existing entities to this new entity.
February – July 2021	Initiate master leasing and housing subsidy arrangements with existing private owners. Identify properties and land for potential acquisition. Establish third-party property management activities in at least two properties. Develop business plan for condominium home ownership and cross-subsidization with at least one supportive housing unit on the property. Develop business plan for licensed board and care. Develop business plan for shared independent living/cooperative housing.
August - October 2022	Secure additional financing necessary for acquisition and rehabilitation of property. Acquire first land trust property using separate funding because innovation funds cannot be used under CCR§ 3910.010(b)(1).
November – July 2022	Renovate and prepare first land trust property for occupancy utilizing model(s) developed by organization.
August – December 2022	Selection and move-in of residents/owners to first land trust property; implementation of supportive housing model for property.
September 2022 – January 2023	Secure additional financing necessary for acquisition and rehabilitation of second property. Acquire second land trust property.

January – September 2023	Renovate and prepare second land trust property for occupancy utilizing model(s) developed by organization.
October – December 2023	Move-in of residents/owners to second land trust property; implementation of supportive housing model for property.
January 2024 – March 2024	Acquisition and rehabilitation of new properties for land trust; expand and test models; continue supportive housing property and subsidy management with staged expansions over time
April – June 2024	Completion of final evaluation report on land trust model; dissemination of findings to key stakeholders

IV. INN Project Budget and Source of Expenditures

1) INN Project Budget and Source of Expenditures

This INN Plan will utilize any remaining AB114 funds that were deemed reverted and returned to the County for use until June 30, 2020. These funds will include funding from FY 10/11 funds as well as non-AB114 funds from FYs 17/18 and FY 18/19.

2) Budget Narrative

Salaries

FY 19/20:

Alameda County Staff Salary and Benefits (benefits are calculated at 50%)

Innovation Coordinator: .25 FTE ($96,616 + 48,308-benefits) x .25 FTE= **$36,231** (Program Specialist classification). This staff will provide MHSA technical assistance and support so that the project is set up correctly and Innovation Regulations are followed.

BHCS Procurement Staff: 4 months at .33 FTE ($105,040 + $52,520-benefits) x .33 =$51,995/12= $4,333/mo x 4 mo= **$17,332** (Supervising Program Specialist classification). This staff will work with the BHCS Project Manager to develop and release the Request for Proposal (RFP) and submit the results to the Board of Supervisors.

BHCS Project Manager from the BHCS Housing Department: 1.0 FTE ($99,403 + 49,702-benefits)= **$149,105** (Senior Program Specialist classification) This staff will oversee the implementation of the Innovation project, such as developing agency and community support and linkages, developing the initial RFP model (in collaboration with the procurement staff) for project launch, ensuring the project achieves its intended innovation objectives, and coordinating the project evaluation and reporting to stakeholders.

Community Land Alliance Staff and Benefits (benefits are calculated at 35%)

Executive Director: 1 FTE ($144,200 + $50,470)= **$194,670** This position will provide primary oversight of the Community Land Alliance, consultants, and staff; development of a community land trust Board of Directors and By-Laws, financing models, family investment model, and sustainability model; cultivating housing projects.

Director of Property Management: 1 FTE (95,000 + 32,250)= **$128,250** This position will develop and integrate supportive housing property management policies and practices, existing best practices and the unique requirements created by the mixed funding sources, such as family/client ownership. Management of supportive housing properties requires unique approaches, workflows, and staffing. This positon will also require a real estate license, as per California law, in order to provide property management and supervise property staff.

Workforce Dev/Training Director: 1 FTE ($103,000 + $36,050)= **$139,050** This position will focus on ensuring staff involved with specific supportive housing projects have the supports and tools necessary to maximize the success of housing projects. Successful supportive housing projects require that staff members involved in specific projects clearly understand their role and responsibilities, have the supervision and support necessary to fulfill their roles, and have training, feedback, and skill development opportunities that enhance their work performance and job satisfaction.

Administrative Assistant: 1 FTE ($60,000 + $21,000)= **$81,000** This position will perform a variety of administrative and clerical tasks. Duties of the Administrative Assistant include providing support to the Executive Director and other Community Land Alliance staff, assisting in daily office needs and managing the agency's general administrative activities.

Total FY 19/20: All Salaries and Benefits=$745,638

FY 20/21:
Includes 3% COLA for ALL personnel listed below

Alameda County Staff Salary and Benefits (benefits are calculated at 50%)
BHCS Project Manager from the BHCS Housing Department: $153,578

Community Land Alliance Staff and Benefits (benefits are calculated at 35%)
Executive Director: $200,510
Director of Property Management: $132,098
Workforce Dev/Training Manager: $143,222
Administrative Assistant: $83,430

Total FY 20/21: All Salaries= $712,837

FY 21/22
Includes 3% COLA for ALL personnel listed below

Alameda County Staff Salary and Benefits (benefits are calculated at 50%)
BHCS Project Manager from the BHCS Housing Department: $158,186

Community Land Alliance Staff and Benefits (benefits are calculated at 35%)
Executive Director: $206,525
Director of Property Management: $136,061
Workforce Dev/Training Manager: $147,518
Administrative Assistant: $85,933

Total FY 21/22: All Salaries= $734,222

FY 22/23
Includes 3% COLA for ALL personnel listed below

Alameda County Staff Salary and Benefits (benefits are calculated at 50%)
BHCS Project Manager from the BHCS Housing Department: $162,931
Community Land Alliance Staff and Benefits (benefits are calculated at 35%)
Executive Director: $212,721
Director of Property Management: $140,142
Workforce Dev/Training Manager: $151,944
Administrative Assistant: $85,511
Total FY 21/22: All Salaries= $756,249

FY 23/24
Includes 3% COLA for ALL personnel listed below

Alameda County Staff Salary and Benefits (benefits are calculated at 50%)
BHCS Project Manager from the BHCS Housing Department: $167,819

Community Land Alliance Staff and Benefits (benefits are calculated at 35%)
Executive Director: $219,103
Director of Property Management: $144,347
Workforce Dev/Training Manager: $156,502
Administrative Assistant: $91,166

Total FY 21/22: All Salaries= $778,937

Total Salaries and Benefits FY 19/20-23/24: $3,727,883
Total Indirect Costs (15%) FY 19/20-23/24: $559,182

TOTAL Personnel Costs: $4,287,066

Operating Costs

The operating costs of the Community Land Alliance are based on the standard County budgeting process where the total personnel costs are multiplied by 30% to closely estimate the operating costs of a new program. Once the project is up and running the operating costs may be adjusted, but funds will not exceed the budgeted request that the MHSOAC approves. Operational costs will include, but not limited to: rent, utilities, communications/phone service, technology maintenance, maintenance services, audit services, furniture, insurance, travel and transportation/mileage, training services, accounting/payroll.

FY 19/20: Total CBO personnel costs=$692,075 x 30%= $162,891
FY 20/21: Total CBO personnel costs=$712,837 x 30%= $167,778
FY 21/22: Total CBO personnel costs=$734,222 x 30%= $172,811
FY 22/23: Total CBO personnel costs=$756,249 x 30%= $177,995
FY 23/24: Total CBO personnel costs=$778,936 x 30%= $183,335

TOTAL Operating Costs (including 15% indirect costs): $994,532

Non Re-occurring Costs

FY 19/20: Incorporation and legal fees $10,000

FY 19/20 start-up costs: $75,000 This will include, but not limited to, furniture, computers, printers, cell phones, signage, first/last month's rent, internet/phone set up, photocopier, printed materials (business cards, agency brochure, etc.) initial software licenses, etc.

TOTAL Non Re-occuring Costs: $85,000

Consultants/Contractors

This project will entail contracting for various areas of expertise including: legal counsel, evaluation services, land trust consultants (including the Burlington Land Trust Association), real estate consultant, Restorative Economics consultant to assist with project management and strategic guidance for community-owned and community governed projects that are exploring new economic models-including sustainability of the land trust entity, expertise to develop multiple agreements/templates such as ground lease, condominium ownership, master lease agreements, rent to own agreements, etc.

Consultation costs (excluding the evaluation) will initially be budgeted at the following amounts:

FY 19/20: $175,000
FY 20/21: $150,000
FY 21/22: $150,000
FY 22/23: $125,000
FY 23/24: $100,000

It should be noted that once the project starts the consultant costs may be adjusted, but funds will not exceed the budgeted request that the MHSOAC approves.

The evaluation costs will be budgeted at $45,000/yr x 5 years=$225,000

TOTAL Contractor/Consultant Costs (including 15% indirect costs): $805,000

Indirect Costs

As a standard practice Alameda County BHCS requests 15% for county administration of the project. This 15% rate has also been applied to the land Trust Alliance CBO that will be created-this percent for the CBO is in alignment and within the approved CBO limit for indirect costs. This 15% applies to Personnel, Operating and Contract expenditures to provide Human Resources, Accounting, Budgeting, Information Technology, Business Services Office, and Legal management of staff and contract positions; rent, utilities, insurance; and other expenses necessary to administer and implement the project.

TOTAL Indirect Costs across all Budget Categories: $793,904

Expend by Fund Source – Narrative

Administration

70% of Innovation Coordinator time= $25,362
70% of BHCS Project Manager time= $554,113
80% of Administrative Assistant time= $344,032

Indirect expenses (as stated above) = $793,904

Total = $1,717,431

Evaluation

30% of Innovation Coordinator time= $7,609
30% of BHCS Project Manager time= $237,486
30% of Administrative Assistant time= $86,008

Evaluator: $45,000/yr x 5 years=$225,000

Total = $556,102

B. New Innovative Project Budget By FISCAL YEAR (FY)*							
EXPENDITURES							
PERSONNEL COSTs (salaries, wages, benefits)		**FY 19-20**	**FY 20-21**	**FY 21-22**	**FY 22-23**	**FY 23-24**	**Total**
1	Salaries	**$745,638**	**$712,837**	**$734,222**	**$756,249**	**$778,937**	**$3,727,883**
2	Direct Costs						**$0**
3	Indirect Costs	**$ 111,846**	**$ 106,926**	**$ 110,133**	**$ 113,437**	**$ 116,840**	**$ 559,182**
4	Total Personnel Costs	**$857,484**	**$819,763**	**$844,356**	**$869,686**	**$895,777**	**$4,287,066**
OPERATING COSTs							**Total**
5	Direct Costs of Land Alliance CBO	**$ 162,891**	**$ 167,778**	**$ 172,811**	**$ 177,995**	**$ 183,335**	**$ 864,810**
6	Indirect Costs	**$ 24,434**	**$ 25,167**	**$ 25,922**	**$ 26,699**	**$ 27,500**	**$ 129,722**
7	Total Operating Costs	**$ 187,325**	**$ 192,944**	**$ 198,733**	**$ 204,695**	**$ 210,836**	**$ 994,532**
NON RECURRING COSTS (equipment, technology)		**FY 19-20**	**FY 20-21**	**FY 21-22**	**FY 22-23**	**FY 23-24**	**Total**
8	start up funds	**$75,000**					**$75,000**
9	Incorporation & legal fees	**$10,000**					**$10,000**
10	Total Non-recurring costs	**$85,000**	**$0**	**$0**	**$0**	**$0**	**$85,000**
CONSULTANT COSTS/CONTRACTS (clinical, training, facilitator, evaluation)		**FY 19-20**	**FY 20-21**	**FY 21-22**	**FY 22-23**	**FY 23-24**	**Total**
11	Direct Costs	**$175,000**	**$150,000**	**$150,000**	**$125,000**	**$100,000**	**$700,000**
12	Indirect Costs	**$26,250**	**$22,500**	**$22,500**	**$18,750**	**$15,000**	**$105,000**
13	Total Consultant Costs	**$201,250**	**$172,500**	**$172,500**	**$143,750**	**$115,000**	**$805,000**
OTHER EXPENDITURES (please explain in budget narrative)		**FY 19-20**	**FY 20-21**	**FY 21-22**	**FY 22-23**	**FY 23-24**	**Total**
14							**$0**
15							**$0**
16	Total Other expenditures	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
BUDGET TOTALS							
Personnel (line 1)		**$745,638**	**$712,837**	**$734,222**	**$756,249**	**$778,937**	**$3,727,883**
Direct Costs (add lines 2, 5 and 11 from above)		**$337,891**	**$317,778**	**$322,811**	**$302,995**	**$283,335**	**$1,564,810**
Indirect Costs (add lines 3, 6 and 12 from above)		**$162,529**	**$154,592**	**$158,555**	**$158,887**	**$159,341**	**$793,904**
Non-recurring costs (line 10)		**$85,000**	**$0**	**$0**	**$0**	**$0**	**$85,000**
Other Expenditures (line 16)		**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
TOTAL INNOVATION BUDGET		**$1,331,058**	**$1,185,207**	**$1,215,588**	**$1,218,131**	**$1,221,613**	**$6,171,599**

C. *Expenditures By Funding Source and FISCAL YEAR (FY)*							
Administration:							
A.	**Estimated total mental health expenditures <u>for ADMINISTRATION</u> for the entire duration of this INN Project by FY & the following funding sources:**	**FY 19-20**	**FY 20-21**	**FY 21-22**	**FY 22-23**	**FY 23-24**	**Total**
1	Innovative MHSA Funds	$ 357,065	$ 328,841	$ 338,031	$ 343,747	$ 349,747	$ 1,717,431
2	Federal Financial Participation						
3	1991 Realignment						$ -
4	Behavioral Health Subaccount						$ -
5	Other funding*						
6	**Total Proposed Administration**	**$ 357,065**	**$ 328,841**	**$ 338,031**	**$ 343,747**	**$ 349,747**	**$ 1,717,431**
Evaluation:							
B.	**Estimated total mental health expenditures <u>for EVALUATION</u> for the entire duration of this INN Project by FY & the following funding sources:**	**FY 19-20**	**FY 20-21**	**FY 21-22**	**FY 22-23**	**FY 23-24**	**Total**
1	Innovative MHSA Funds	$ 113,540	$ 107,759	$ 109,642	$ 111,581	$ 113,579	$ 556,102
2	Federal Financial Participation						$ -
3	1991 Realignment						$ -
4	Behavioral Health Subaccount						$ -
5	Other funding*						$ -
6	**Total Proposed Evaluation**	**$ 113,540**	**$ 107,759**	**$ 109,642**	**$ 111,581**	**$ 113,579**	**$ 556,102**
TOTAL:							
C.	**Estimated TOTAL mental health expenditures (this sum to total funding requested) for the entire duration of this INN Project by FY & the following funding sources:**	**FY 19-20**	**FY 20-21**	**FY 21-22**	**FY 22-23**	**FY 23-24**	**Total**
1	Innovative MHSA Funds	$ 1,331,058	$ 1,185,207	$ 1,215,588	$ 1,218,131	$ 1,221,613	$ 6,171,599
2	Federal Financial Participation						$ -
3	1991 Realignment						$ -
4	Behavioral Health Subaccount						$ -
5	Other funding*						$ -
6	**Total Proposed Expenditures**	**$ 1,331,058**	**$ 1,185,207**	**$ 1,215,588**	**$ 1,218,131**	**$ 1,221,613**	**$ 6,171,599**
*If "Other funding" is included, please explain.							

Behavioral Health Workforce Education and Training Needs Assessment Report

Alameda County Behavioral Health Care Services
Workforce, Education, and Training Unit

Prepared by:

Resource Development Associates

February 2018

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Introduction

At the end of Fiscal Year 2017/18, Alameda County Behavioral Health Care Services (BHCS), Workforce Development, Education and Training (WET) Unit will be completing a 10-year block grant from the Mental Health Services Act (MHSA, Prop. 63). As part of the effort to realign funding sources, the WET Unit conducted a mixed-methods Needs Assessment of workforce and training needs in Alameda County for the next three years. The current report builds on the 2015 Needs Assessment that aimed to prepare the behavioral health workforce for reforms made through implementation of the Affordable Care Act. This assessment shifts focus to workforce capacity building through behavioral health career pipeline development, training opportunities, and addressing strategies to recruit and retain hard to fill positions.

The BHCS WET Unit partnered with Resource Development Associates (RDA) to lead the needs assessment activities. RDA worked with WET Unit leadership to develop the qualitative and quantitative assessment tools for this evaluation. This report presents quantitative survey findings and qualitative data gathered from a focus group and from survey respondents. The outreach for focus group and survey participants was composed of BHCS and contracted community based organization (CBO) executive leadership, program directors, and CBO staff.

Needs Assessment Methodology

Qualitative Methods

In November 2017, BHCS WET convened a focus group of behavioral health service providers from Alameda County and community based organizations (CBO). Twenty individuals joined the focus group; respective organizations included:

- Afghan Coalition
- BHCS
  - Pool of Consumer Champions
  - Integrated Health Services
  - Vocational Services
  - WET
  - Network Office
  - Office of Family Empowerment
- Peers Envisioning and Engaging in Recovery Services (PEERS)
- East Bay Agency for Children (EBAC)
- Family Education and Resource Center (FERC)
- Axis Health Services
- A Better Way
- FACES – Public Health Institute (PHI)
- Tiburcio Vasquez Health Center (TVHC)
- Hume Center
- Asian Health Services (AHS)
- Pacific Center
- Tri-City Health Services

The focus group followed a structured set of questions to measure: 1) the current and projected occupational needs of the behavioral health workforce; 2) efforts to support workforce education and training; and 3) work-based learning opportunities. RDA qualitatively coded the focus group transcript

and conducted a thematic analysis to describe the emerging strengths and challenges facing the behavioral health workforce in Alameda County.

Quantitative Methods

In December 2017, as part of the needs assessment, RDA conducted an online survey of Alameda County behavioral health organizations about current workforce capacity, gaps, and needs. RDA reviewed the *2014 BHCS WET Survey* and collaborated with WET team leadership to create the 44-question survey. The survey addressed the following areas:

(1) Behavioral Health Workforce Staffing
(2) Cultural Capacity of Workforce
(3) Family and Peer Workforce
(4) Pipeline Programs
(5) Training Needs.

Table 1. Survey Respondents

Role at Organization	Percentage of Respondents (n=55)
Executive Director/ CEO	38.2%
Division/ Department Director	23.6%
Director of Training	5.5%
Other	32.7%

WET team leadership identified key stakeholders and RDA administered the survey to these individuals between November and December 2017. The survey link was sent to 94 individuals representing the County and a diverse set of CBOs. In total, 55 people completed the survey and 14 people partially completed the survey. Quantitative data analysis consisted of the development of descriptive statistics, including the calculation of frequencies and percentages. Tables 1-3 describe survey respondents' in terms of their career position and the size and budget of their organization.

Table 2. Annual Budgets

Annual Budget	Percentage of Respondents (n=54)
More than $2 million	64.8%
$1,000,001 – $2 million	14.3%
$701,000 – $1 million	5.6%
$300,000 - $700,000	7.4%%
Under $300,000	7.4%

Table 3. Organizations Represented in the Survey

Size of Organization	Percentage of Respondents (n=54)
Under 25 employees	31.5%
26-50 employees	16.7%
51-100 employees	13%
101-200 employees	13%
More than 200 employees	25.9%

Workforce Capacity

Workforce capacity refers to the ability of Alameda County's behavioral health workforce to provide culturally, ethnically, linguistically diverse, and skilled staffing to effectively meet the behavioral health needs of county residents. RDA asked the County and CBOs to report shortages for specific occupations in the behavioral health workforce. Table 4 shows the greatest staff shortages for respondents who selected the respective position as applicable to their organization. When asked to rank occupations increasing in demand, survey respondents chose Licensed Clinical Social Worker (LCSW) and Licensed

Marriage Family Therapist (LMFT) most frequently as the number one occupation increasing in demand (19.6% and 13.7%, n=56). Table 5 shows the positions that were most frequently included in the top five increasing demand occupations.

Table 4. Greatest Staff Shortages

Occupation	Respondents Experiencing a Staff Shortage
Licensed Clinical Social Worker (LCSW)	70%
Employment Services Staff/Housing Services Staff	70%
Psychiatrist Child/Adolescent	68%
Psychiatric Mental Health Nurse Practitioner	68%
Substance Abuse Counselor	58%

Table 5. Occupations Increasing in Demand

Occupation	Number of Instances Included in the Top 5
Licensed Clinical Social Worker (LCSW)	31
Substance Abuse Counselor	25
Case Manager/Service Coordinator	23
Licensed Marriage and Family Therapist (LMFT)	22
Mental Health Rehabilitation Counselor	14

Across survey responses, organizations most commonly reported an increasing demand and shortage of LCSW's. This is somewhat expected as LCSW's are one of the most common clinical titles in behavioral healthcare due to the wide range of clinical settings, provider roles, and populations that an LCSW can serve. Although demands for LCSW's are likely to continue, the combination of reported shortage and increasing demand may indicate a need for continued efforts to expand the County's LCSW workforce.

Similarly, survey findings indicate that demand is increasing for core behavioral health positions such as Case Managers, License Marriage and Family Therapists, and Mental Health Rehabilitation Counselors. It is expected that behavioral health systems will always experience some levels of demand for core positions due to the versatile skill sets they bring to treat a population of diverse needs. However, the demand for core positions may indicate a skill and training gap among the current and perspective behavioral health workforce. Alameda County should take steps to ensure that the current and future workforce are equipped with the skills and required licensure/certification to meet the County's current behavioral health staffing shortages.

Focus group participants reported a lack of providers that can serve individuals with co-occurring mental health and substance use disorders in Alameda County. Similarly, survey results point to a shortage and growing demand for substance abuse counselors as shown in Table 4 and Table 5. This trend is likely due to both an increase in the prevalence of substance use disorder among Alameda County residents as well as growing awareness of the prevalence of co-occurring disorders among behavioral health providers.

Reported shortages for child/adolescent psychiatrists and psychiatric mental health nurse practitioners could be reflective of the high levels of education and training required for these highly specialized

positions. Additionally, child/adolescent psychiatrists work in clinical settings and provide medication services for children, youth, and teenagers. Not all behavioral health organizations offer these services for their clients. Recruiting more psychiatric mental health nurse practitioners into the workforce could offer opportunities to expand medication management capacity and other specialized services in the county.

Lastly, focus group participants explained that staff with high-need skills are difficult to retain due to their position's low wages and the high level of need amongst clients. Wages do not reflect the current cost of living in the Bay Area, and it is difficult to recruit individuals to move to Alameda County to fill these positions.

Workforce Diversity

County and community based organizations (CBOs) report working with a diverse community in Alameda County. Qualitative data analysis shows that the County and CBOs are interested in hiring staff that (1) reflect the communities they serve and (2) share lived experience with their clients.

Documented efforts for staff recruitment include:

- Tabling events with county interns nearing graduation
- Partnerships with universities to attract first and second year Master's students
- Community based outreach and advertising on professional networks

Despite these recruiting efforts, focus group participants noted a lack of diversity at all workforce and management levels. Organizations stressed a lack of representation from communities across a range of ethnicities, genders, religious backgrounds, and sexual and cultural identities. Among these groups, participants highlighted the need for African American staff as particularly strong.

> *"We need multi-cultural staff representation at various levels of the workforce – the mid-management and executive-management level."*
> *– Focus Group Participant*

Similarly, participants felt that the lack of cultural and linguistic representation in the current public mental health workforce in Alameda County contributed to unfamiliar and, in some cases, negative views of behavioral health careers among community members. Some participants also mentioned that many community members frown upon a career in behavioral health due to the level of financial investment in education required compared to the level of compensation expected.

Bilingual Capacity

In addition to specific occupations, focus group participants expressed shortages in bi-lingual and multi-lingual staff. As depicted in Table 6, Alameda County behavioral health providers serve a wide range of linguistic and cultural communities. Focus group participants indicated that hiring bi-lingual and multi-lingual behavioral health staff was

> *"Hiring bilingual staff is very difficult. In the Bay Area, it is highly competitive. Huge institutions pay better than non-profits. Unless the person really has a very deep connection with what they do, they may turn around and leave…"*
> *–Focus Group Participant*

especially challenging for more specialized positions, such as licensed clinical roles. Most participants felt that limited linguistic and cultural fluency among providers likely have negative impacts on client outcomes.

Table 6. High Priority Languages

Language	Percentage of Respondents Selecting as High Priority (n=65)
Spanish	90.8%
Cantonese	41.5%
Mandarin	38.5%
Farsi	32.3%
Vietnamese	32.3%

Consumer and Family Member Staff

Nearly half (49.2%) of survey respondents reported at least one position designated for consumer and family members in their organization. Many focus group participants advocated for increasing the number of these positions and addressing significant challenges facing individuals currently in these roles. Some participants stressed the importance of continued support and training for peer partners.

> *"Our CBO's do a good job of hiring peers. However, they are still not in every part of behavioral health services…We would like to see more peers embedded in county service teams."*
> *–Focus Group Participant*

For organizations that employ consumer and family members, some reported specific training and/or certification requirements. These include Wellness Recovery Action Planning (WRAP) certification, BestNow training, and peer certification. Other organizations, however, noted lived experience as the only and most important requirement. Table 7 shows the number of positions available in organizations with designated consumer or family member employees.

Table 7. Designated Consumer or Family Member Positions

Number of Designated Consumer or Family Member Positions	Percentage of Respondents with Available Positions (n=27)
1-3	48.1%
4-6	29.6%
7-9	7.4%
10 or more	14.8%

Survey respondents noted other strategies for involving consumers and family members in service provision and/or practice and policy development. The most common strategies include:

- Involving consumers and family members in workgroups, advisory councils, stakeholder meetings, planning or policy groups (64.7%, n=51)

- Recruiting consumers and family members on boards and other positions of leadership (54.9%, n=51)
- Meeting and/or job accommodations (52.9%, n=51)

Behavioral Health Skill Needs

As discussed in the focus group, Alameda County's behavioral health workforce serves a diverse population in terms of clinical diagnoses, target populations, geography, and cultures. To effectively engage and treat this population, participants discussed several key growth areas. The first was an integrated skill set to treat populations with multiple diagnoses, especially co-occurring mental health and substance use disorders. Both focus group participants and survey findings indicated that expanding substance use disorder capacity among behavioral health providers is a growing demand. A large share of current behavioral health providers lack the necessary knowledge, skills, and training.

> *"I am interested in learning more about the interface in mental health and substance use… [We need] opioid use disorders strengthened in terms of training, recruitment, clinical assessment and referrals."*
> *– Focus Group Participant*

Secondly, participants expressed the need for staff able to work with low-income persons, children, and transitional age youth (TAY). In particular, participants expressed a lack of representation of providers with lived experience or work experience and training with children, youth, and TAY. Focus group and survey participants suggested increasing the number of peer advocate positions from low income and TAY populations to increase outreach and engagement of consumers in these populations.

> *"Most of my staff have strong skills working with the adult population. We really lack the skills in working with children and youth. It is often hard to find somebody like that."*
> *–Focus Group Participant*

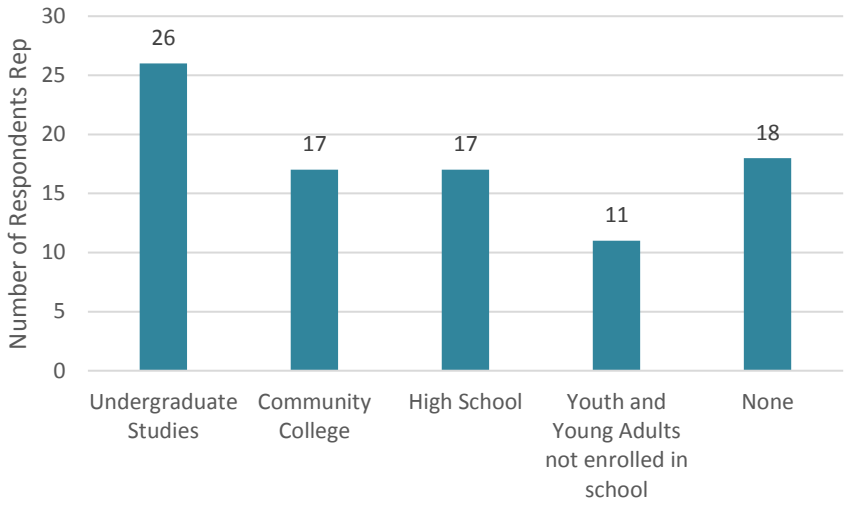
Serving populations with particular conditions was noted as another area of growth. Some focus group participants felt the system as a whole lacked providers with the training, experience and ability to treat co-occurring mental health. Similarly, providers noted an increasing trend of serving clients with mental health needs that also have a diagnosis of autism spectrum disorder and felt there may be need of building providing capacity in serving this population as well. Lastly, providers felt that another skill area for growth was their overall capacity to provide trauma-informed care as well as serve clients experiencing post-traumatic stress disorder or related trauma.

Internship Opportunities and Pipeline Programs

Within Alameda County, a range of internship opportunities and pipeline programs are currently available for middle school, high school, and undergraduate students. As depicted in Figure 1, most opportunities are available to undergraduates, community college students, and high school students. The lowest number of opportunities were reported for youth and young adults not enrolled in school. One third of survey respondents reported offering no opportunities, and so there is considerable room to expand internship and pipeline programs. When asked how many student interns they anticipate hosting in Fiscal

Year 2017-18, the most common type of interns providers hosted were graduate-level social work student and nursing students.

Figure 1. Availability of Work-based Learning Opportunities and Internships



Internship and Pipeline Programs Needs

Focus group participants described the value and need for internship programs to bolster the behavioral health workforce. Of participants surveyed, only 30.9% reported providing summer work-based learning internships. At the high school level in particular, participants discussed the difficulty of encouraging students to pursue careers in mental and behavioral health. An expansion of internship opportunities could help develop a career pipeline. Participants in both the focus group and survey indicated strong interest in developing clear and consistent career pathways for mental health. However, they also reported barriers to hosting student interns, as shown in Table 8. The most commonly reported barriers were related to a lack of resources to support an internship, such as a lack of staff time (48%), difficulty recruiting qualified interns (26%), and a lack of qualified staff to supervise interns (26%). Other common themes were the development and maintenance of relationships with academic institutions and meeting organizational requirements for hosting interns. In both cases, organizations may benefit from more technical assistance and support from BHCS in hosting interns.

> *"Stigma around mental health and behavioral health careers in general exist…It is difficult at the high school level to say you need to get a Master's…It's very expensive to attain with limited salary. It's a hard sell."*
> *–Focus Group Participant*

Table 8. Barriers to Hosting Student Interns

Barriers to Internship Programs	Percentage of Respondents (n=56)
Lack of staff time to train, supervise, and/or support interns	48.2%
Need for more support in developing partnerships with institutions	26.8%
Difficulty in recruiting qualified interns with needed skills (such as bilingual, customer service, etc.)	26.8%
Lack of staff who are qualified to supervise interns	23.2%
Burdensome requirements from institutions	17.9%

When asked about needed resources, survey respondents marked funding as the highest anticipated need for creating more internship opportunities, as shown in Table 9. Similarly, organizations with experience hosting interns with limited work experience stressed the need for organizations to be paid for hosting high school and youth interns due to time, resource, and supervision demands. If resources were available, many survey respondents reported willingness to create work-based learning opportunities for undergraduate students (77.1%, n=48) and community college students (61.7%, n=47).

Table 9. Resources Needed to Create More Internship Opportunities

Resource	Percentage of Respondents (n=50)
Funding	86%
Staff training	68%
Training materials/ curriculum	56%
Staff interest to supervise	54%
Space	44%

Workforce Opportunities

To retain staff and support a diverse and inclusive behavioral health workforce, focus group participants reported continuing education, trainings, and established practices for professional development as extremely important.

Table 10 shows the most frequently selected top priority trainings with respect to general, mental health/ substance use disorder, and population-specific trainings.

Table 10. aTop Priority Trainings

General Behavioral Healthcare Trainings	Percentage of Respondents Selecting as Top Priority (n=54)
Cultural humility and responsiveness	63%
Knowledge and delivery of "wellness, recovery, resiliency" services	38.5%
Mental Health/Substance Use Disorder Treatment Training	**Percentage of Respondents Selecting as Top Priority (n=54)**
Working collaboratively with clients and families	53.7%
Crisis Assessment and Intervention (danger to self, danger to others, grave disability)	50%
Population-Specific Trainings	**Percentage of Respondents Selecting as Top Priority (n=54)**
Lesbian/ Gay/ Bisexual/Transgender (LGBT) issues	35.2%
TAY – Transition to Independence	31.5%

Many focus group participants and survey respondents commented on the quality and diversity of BHCS trainings. Some individuals reported strong trainings on compassion fatigue, WRAP, and resource sharing between consumers and providers. In terms of gaps, survey respondents noted an increasing need for trauma-informed trainings and trainings on evidence-based practices. Another notable challenge was providing career ladders for employees. When asked about barriers that prevent an organization from offering support to license-eligible employees, 51.2% of survey respondents reported a lack of licensed staff to provide supervision that meet licensing requirements. Additionally, 41.9% of respondents noted retention following licensure (i.e. staff leave organization once license is obtained) as a barrier to support.

> *"We offer something called co-learning. A process that we integrated to bring parents and providers together to make change together. We've trained folks at numerous CBO's and within the county. The purpose is to co-create resources."*
> *–Focus Group Participant*

Loan Assumption Programs

Most survey respondents (79.2%, n=53) reported that they would participate in a local, county loan assumption program similar to the Mental Health Loan Assumption Program (MHLAP) if given the opportunity. Less than half (41.3%, n=46), however, noted that their staff were taking advantage of MHLAP. Some respondents cited not being aware of the program or being ineligible as reasons for low staff participation.

Implications and Recommendations

This Needs Assessment identified several challenges that affect the ability of BHCS to recruit, train, and retain a diverse and inclusive workforce. Findings suggest that Alameda County WET increase their capacity around (1) incentives for workforce development, (2) efforts to recruit staff reflective of the community, and (3) pipeline programs.

Incentives for Workforce Development

Several key positions emerged as increasing in demand and experiencing shortage. For these specific positions, BHCS might consider adding financial or other incentives for individuals to fill and stay in these roles. Bilingual and multi-lingual staff especially, should be further incentivized to maintain their high-demand positions. Additionally, BHCS might bolster efforts to support non-master levels employees pursue their master's degree. Individuals who are already social workers could benefit from the addition of an intermediate step between level 1 and level 2 positions.

Efforts to Recruit Staff Reflective of the Community

The need for an inclusive workforce was highly evident. Dedicated time, staff and funding should be allocated to increase recruitment efforts for multilingual, multicultural, and ethnically/racially diverse staff at all organizational levels. This may include the expansion of grant and loan opportunities for individuals to pursue undergraduate and graduate degrees, allowing them to work in mental and behavioral health. BHCS might also consider qualifying lived experience, as well as education and training, when measuring a job candidate's capability for employment.

Continue to Build Capacity

Cultural humility and responsiveness as well as the ability to collaborate with family members were highly desired trainings. Amendment and expansion of current BHCS training programs in these areas could lead to improved interpersonal relationships between consumers, family members, and agency staff. BHCS WET Unit should also look for opportunities to engage many of the stakeholder groups currently supporting BHCS such as the African America Steering Committee, the Consumer Advisory Committee, and the Family Advisory Committee for input on both training needs and topics. Similarly, provider organizations that work directly within the County's various linguistic and cultural communities may also serve as valuable source on understanding behavioral health workforce and training needs as they relate to different communities.

Pipeline Programs

This report found significant interest in creating more opportunities for students to interact with mental and behavioral health workers. Internship stipends for undergraduates and funding for dedicated staff time to mentor students at all education levels should be increased to allow these opportunities to exist.

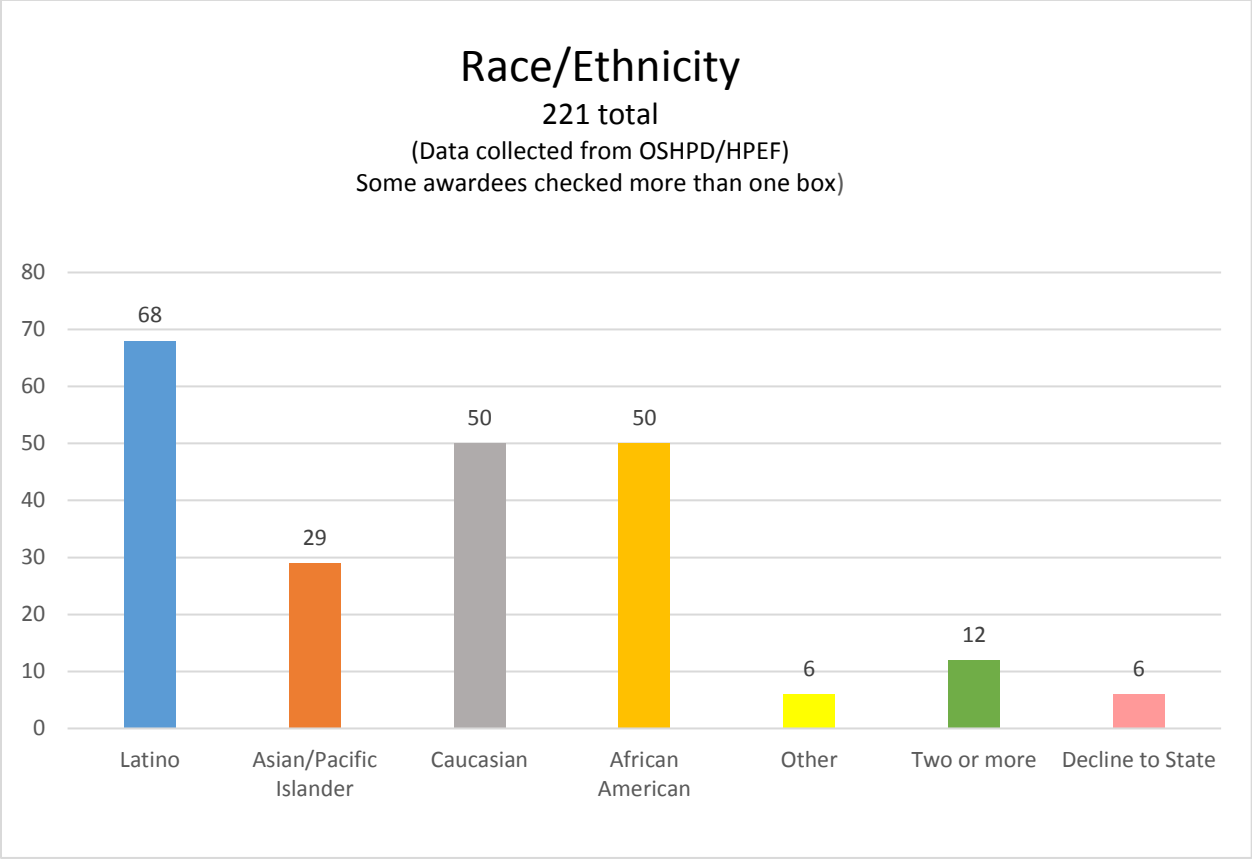
ACBHS should also consider providing financial support for organizations willing to host interns with limited work experience such as high school students and youth. Providers made it clear, this would eliminate many of the time and resource challenges they have experienced hosting interns if there was monetary compensation to cover the cost.

State Mental Health Loan Assumption Program (MHLAP)
Alameda County Behavioral Health Care Services (BHCS)
FY 2010-18 Awardee Demographics & Employment Retention

- From July 30 through Aug 13, 2018, BHCS Workforce Development Unit conducted a survey of the 216 Alameda County MHLAP awardees from **all 7 cycles; Fiscal years 2010/11 - 2017/18.** The purpose of the survey was to measure behavioral health employment retention within Alameda County BHCS of "hard to fill/retain" clinical positions, and measure if MHLAP's financial incentive program was able to increase diversity and language capacity within our services.

- **Data Sources**: Language and Ethnicity data was provided by the Office of Statewide Health Planning and Development (OSHPD) /Health Provider Education Foundation (HPEF). Total 216 awardees. Employment retention information was obtained via survey monkey by WET staff. Of the 216 sent the survey 104 responded (48%).

ETHNICITY



State Mental Health Loan Assumption Program (MHLAP)
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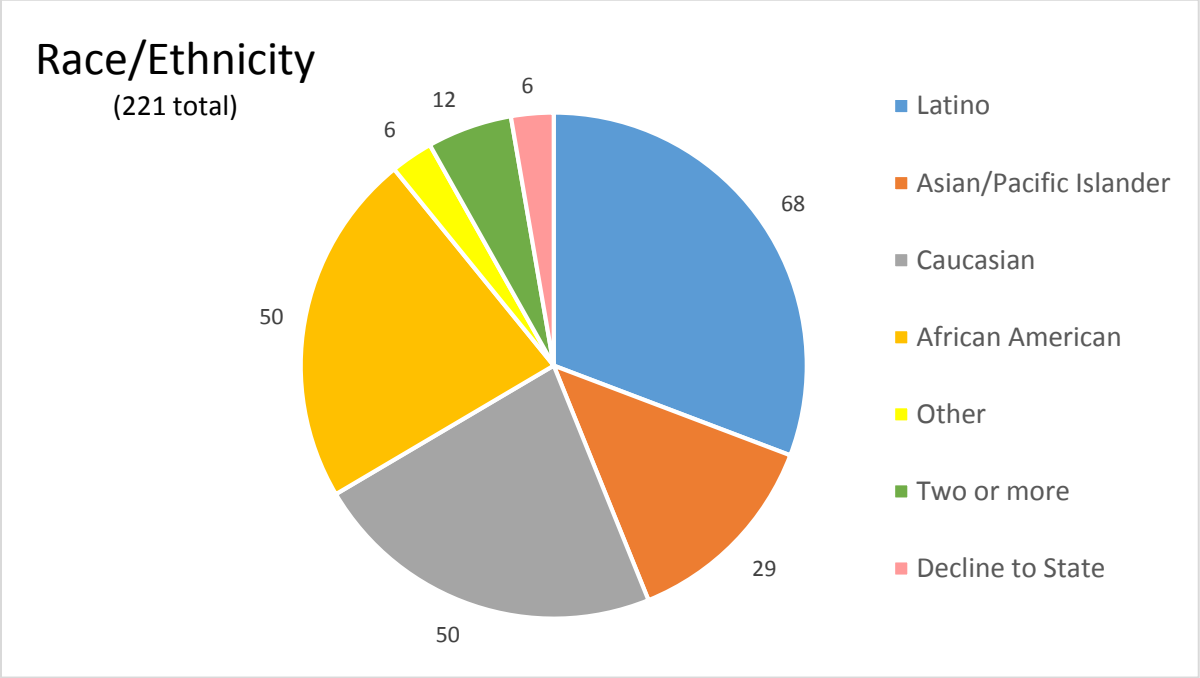
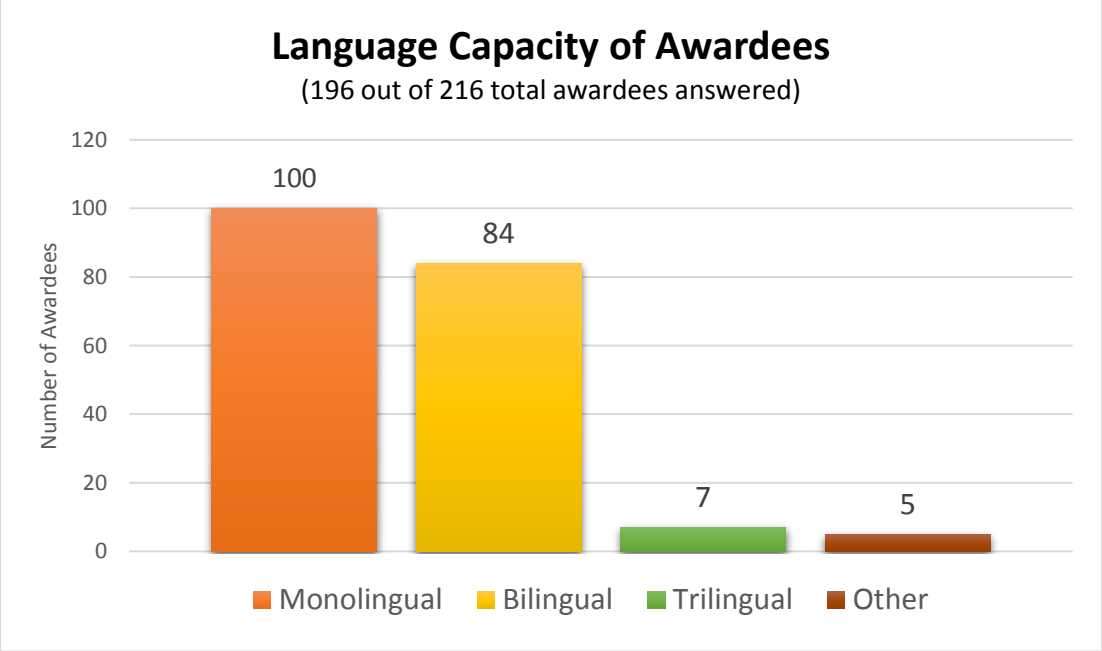


LANGUAGE CAPACITY



State Mental Health Loan Assumption Program (MHLAP)
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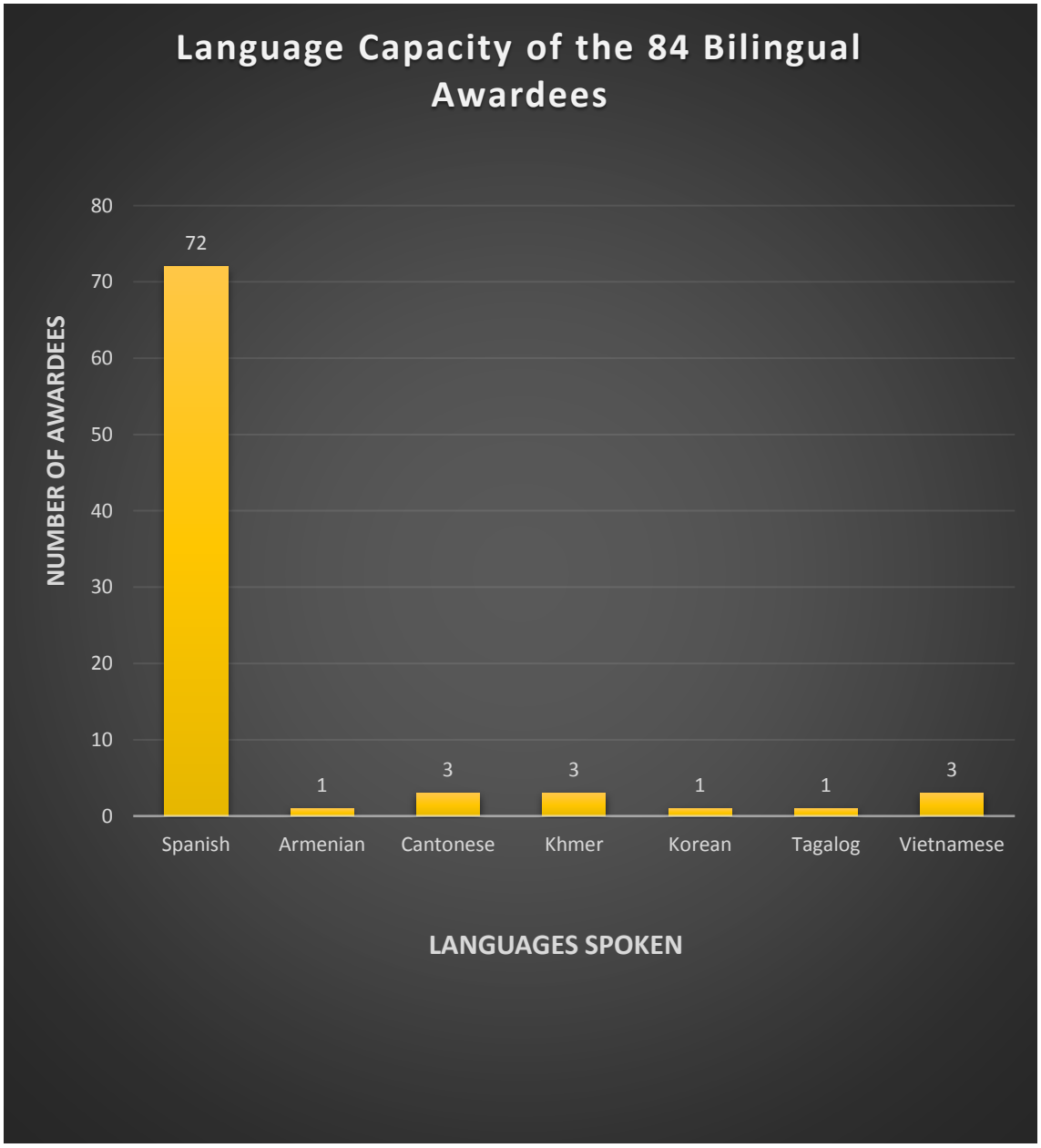
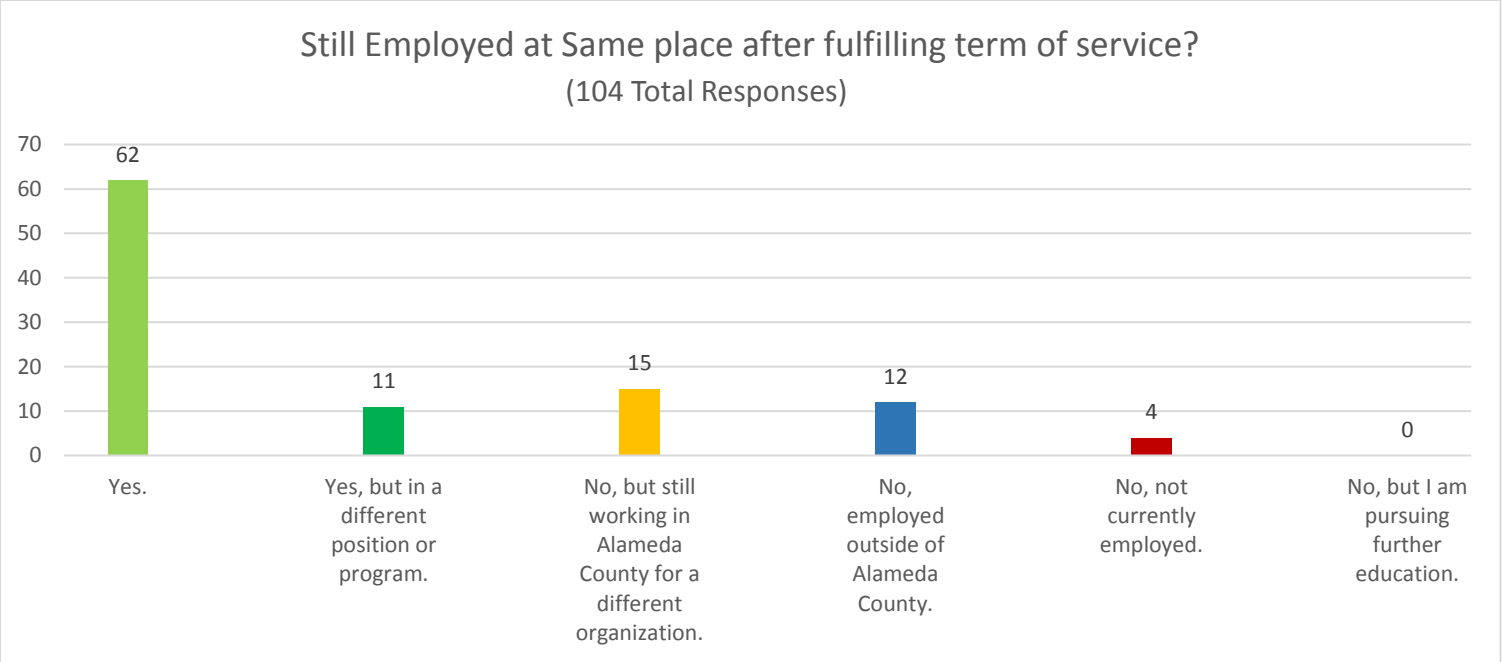


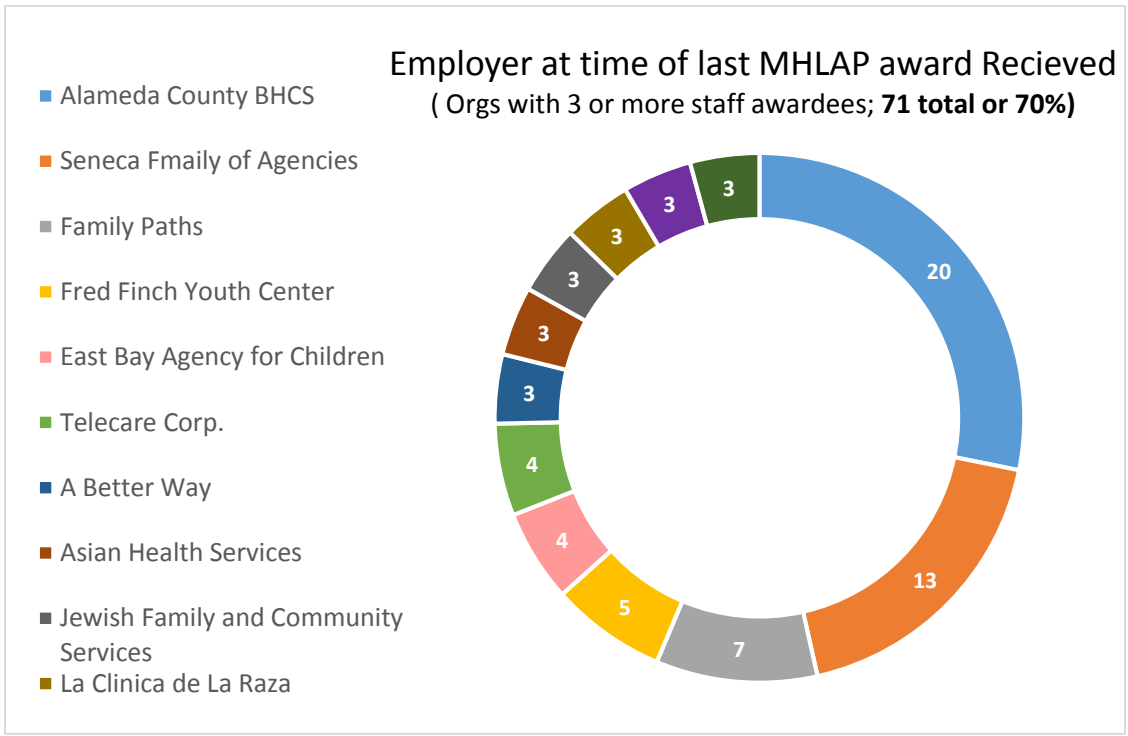
State Mental Health Loan Assumption Program (MHLAP)
Alameda County Behavioral Health Care Services (BHCS)
FY 2010-18 Awardee Demographics & Employment Retention

Employee Retention

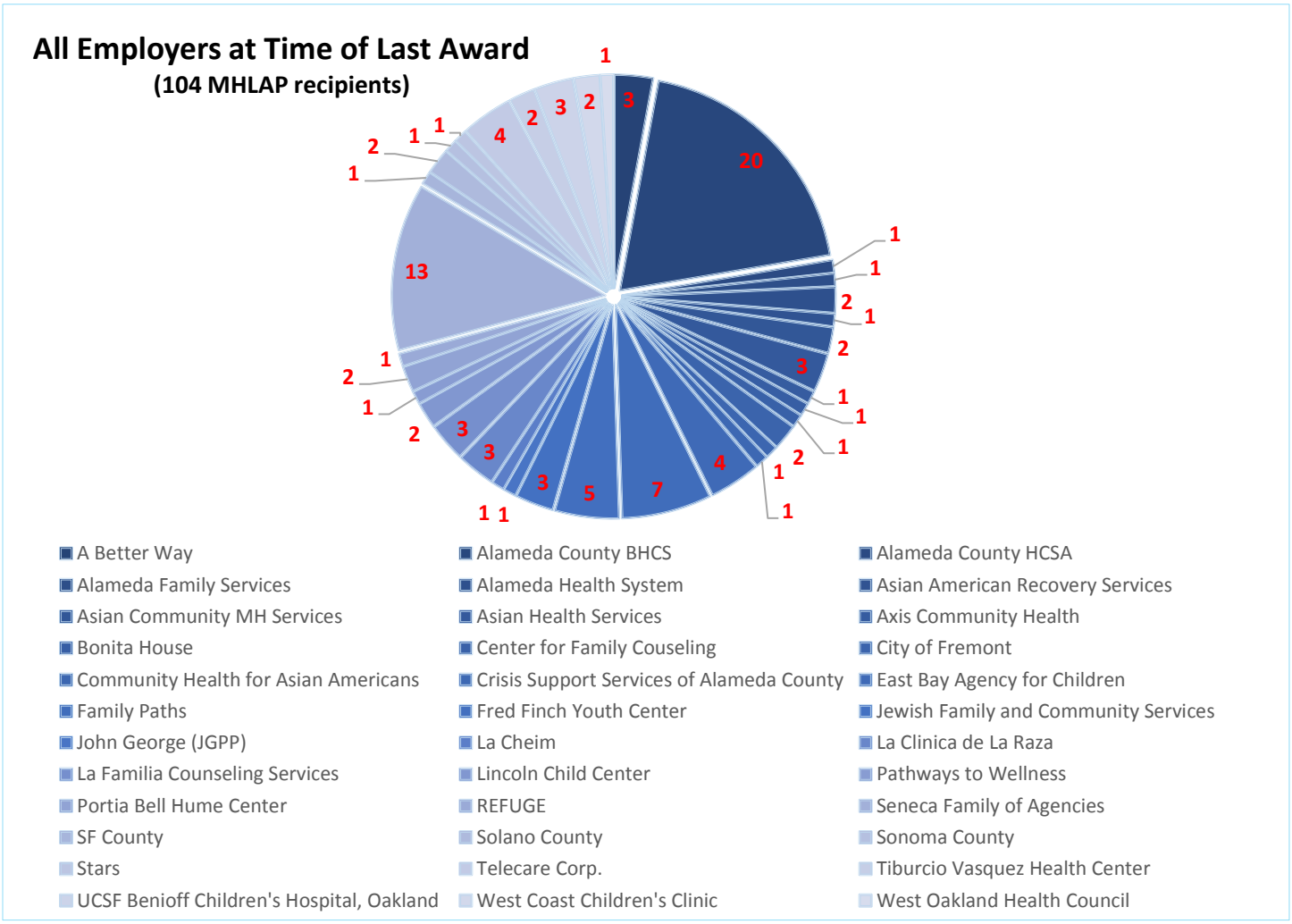
All 216 MHLAP awardees over seven MHLAP cycles were emailed employment retention surveys via Survey Monkey in August 2018, **104 responded**. The data below accounts for **48%** of the total 216 awardees.

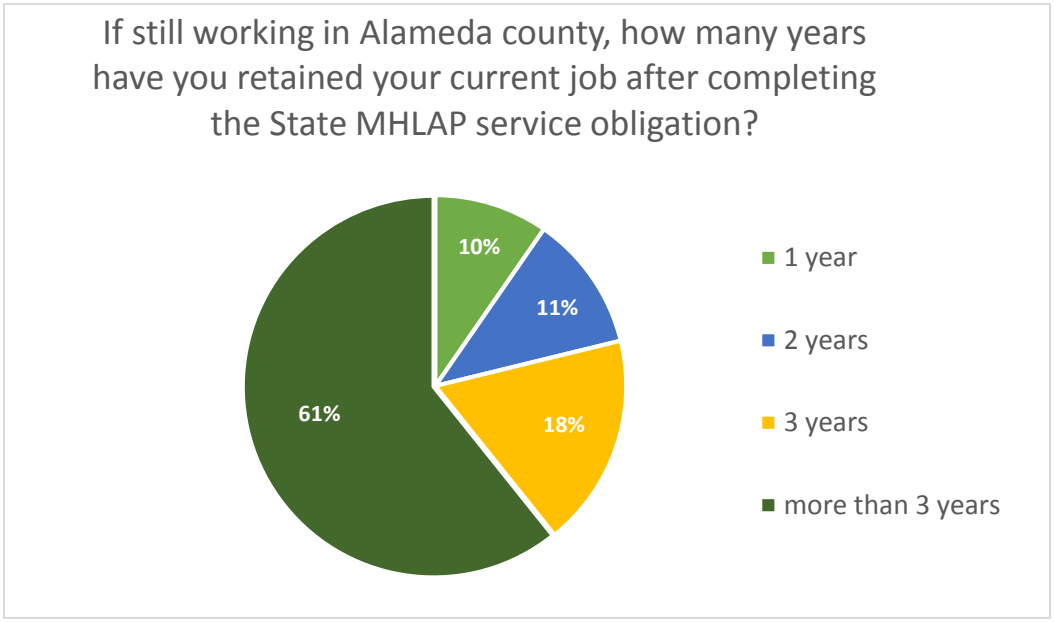


Outcome: **84.6%** of Alameda County MHLAP awardees continue to work within the county of Alameda after fulfilling their last 12 month of service obligation.

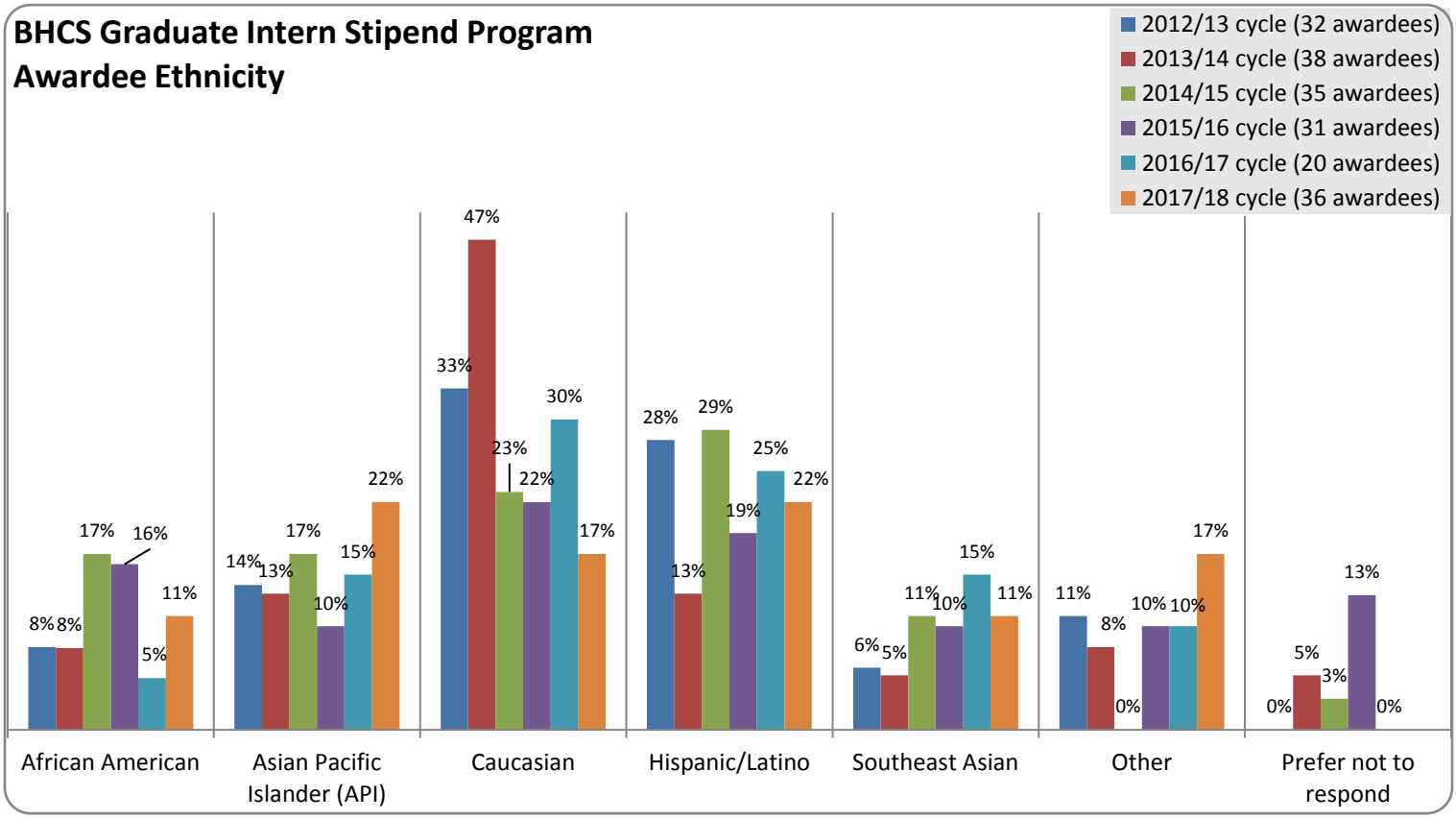


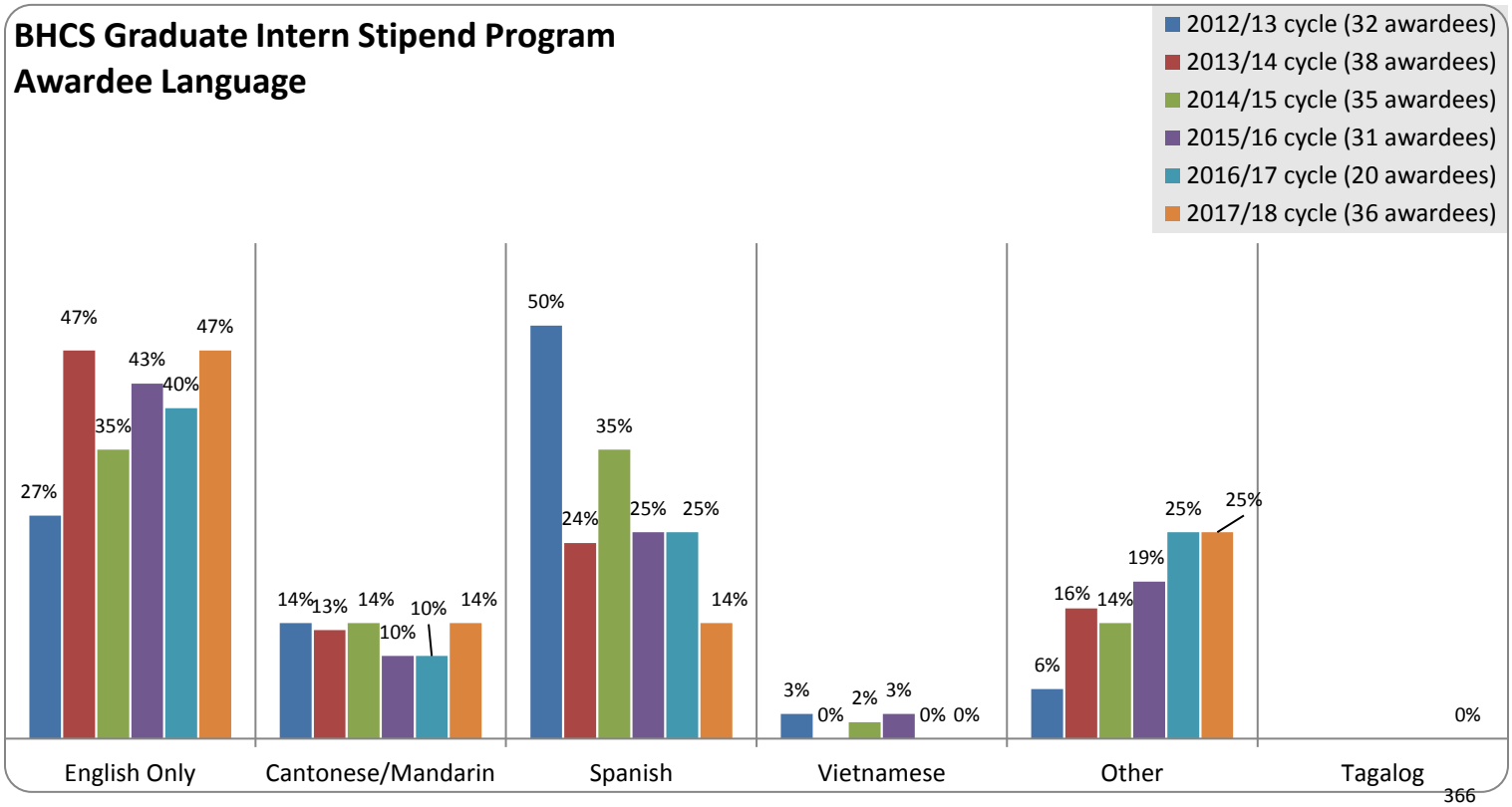
State Mental Health Loan Assumption Program (MHLAP)
Alameda County Behavioral Health Care Services (BHCS)
FY 2010-18 Awardee Demographics & Employment Retention



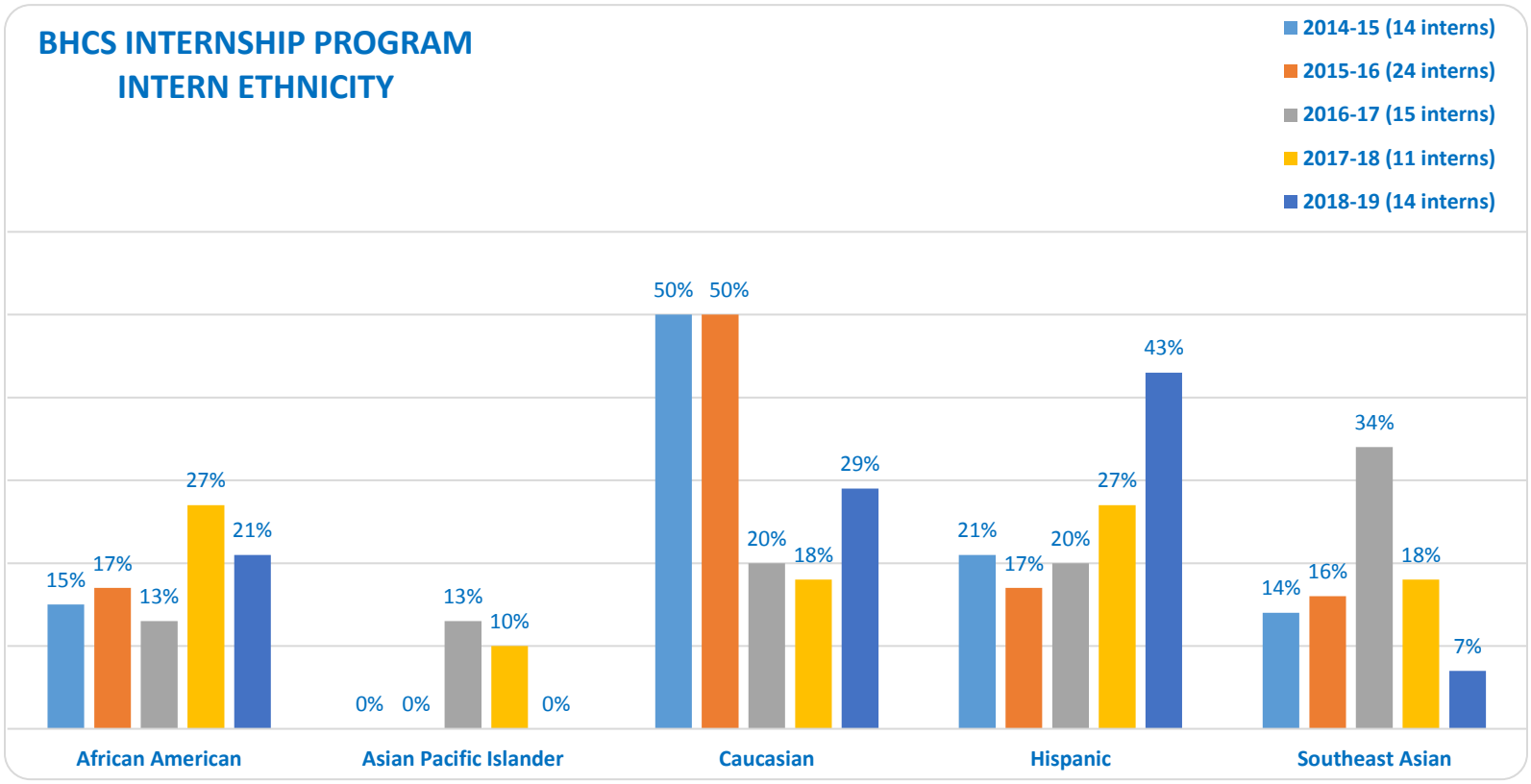


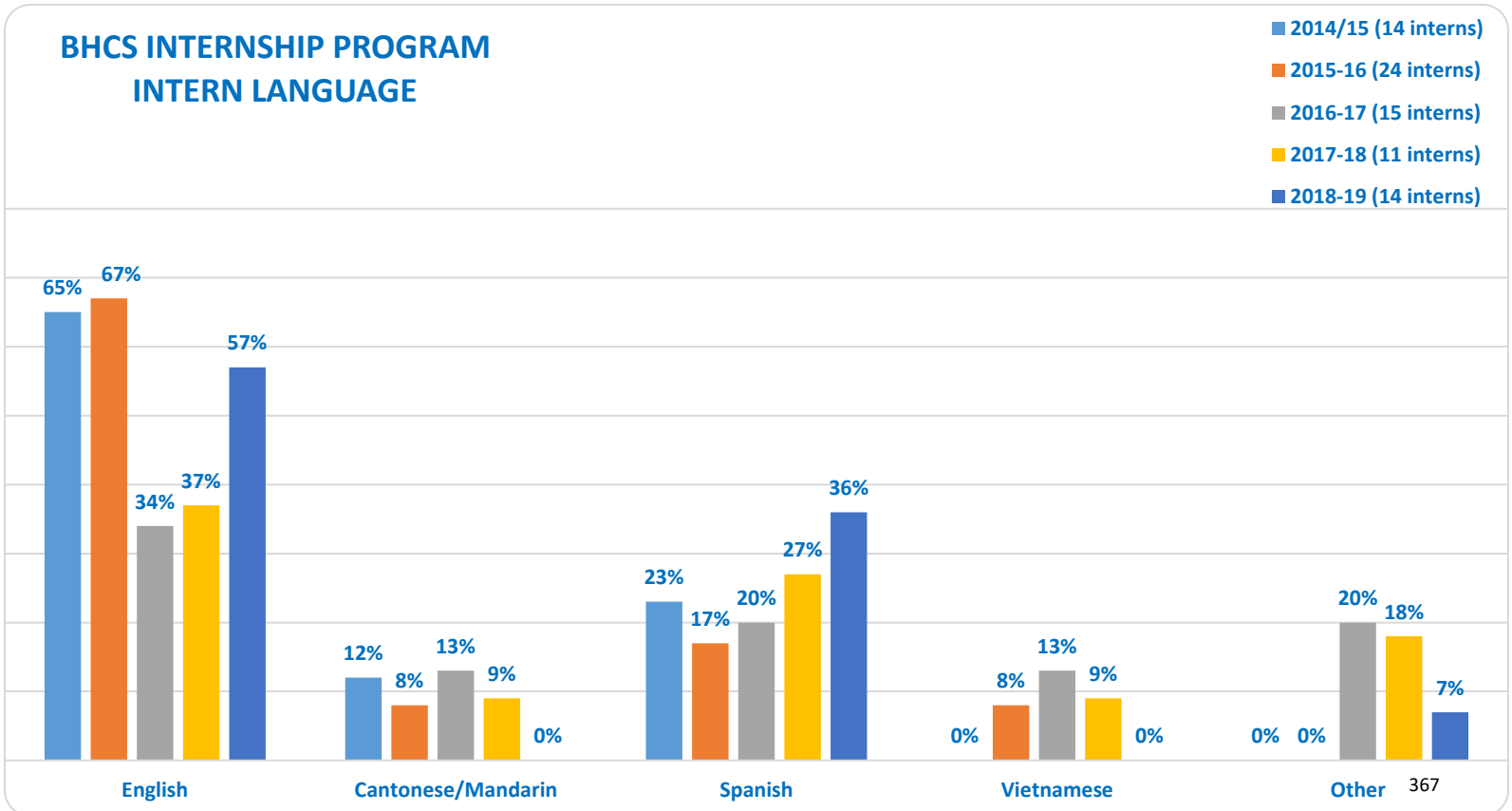
Alameda County Behavioral Health Care Services (BHCS)
Workforce Development, Education and Training
Graduate Intern Stipend Program
FY 2012-18 Awardee Ethnicity and Language





Alameda County Behavioral Health Care Services (BHCS)
Workforce Development, Education and Training
Graduate Intern Program
FY 2014-19 Intern Ethnicity and Language





Alameda County Behavioral Health Care Services

Asian American, Native Hawaiian and Pacific Islander Utilization Report

Executive Summary

Spring, 2018

Funded by Mental Health Services Act (MHSA)

Compiled by Rocco Cheng and Associates (RCA)

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Alameda County Behavioral Health Care Services Mission, Envision

Our Mission *is to maximize the recovery, resilience and wellness of all eligible Alameda County residents who are developing or experiencing a serious mental health, alcohol or drug concern.*

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

ACBHCS Values

Access

We value collaborative partnerships with consumers, families, service providers, agencies and communities, where every door is the right door for welcoming people with complex needs and assisting them toward wellness,recovery and resiliency.

Consumer & Family Empowerment

We value, support and encourage consumers and their families to exercise their authority to make decisions, choose from a range of available options and to develop their full capacity to think, speak and act effectively in their own interest and on behalf of the others that they represent.

Best Practices

We value clinical excellence through the use of best practices, evidence based practices, and effective outcomes, including prevention and early intervention strategies, to promote well being and optimal quality of life. We value business excellence and responsible stewardship through revenue maximization and the wise and cost-effective use of public resources.

Health & Wellness

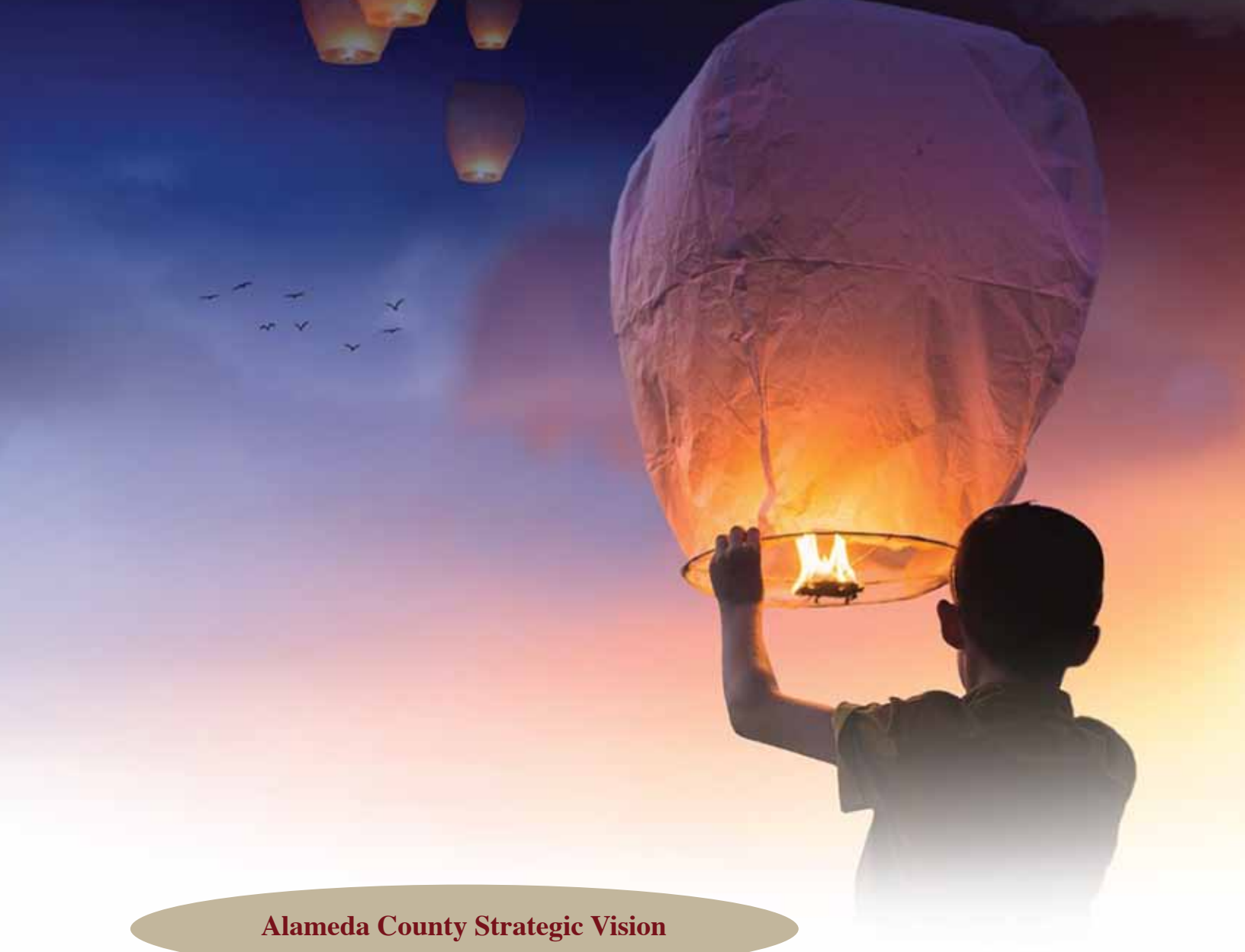
We value the integration of emotional, spiritual and physical health care to promote the wellness and resilience of individuals recovering from the biological, social and psychological effects of mental illness and substance use disorders.

Culturally Responsive

We honor the voices, strengths, leadership, languages and life experiences of ethnically and culturally diverse consumers and their families across the lifespan. We value operationalizing these experiences in our service settings, treatment options, and in the processes we use to engage our communities.

Socially Inclusive

We value advocacy and education to eliminate stigma, discrimination, isolation and misunderstanding of persons experiencing mental illness and substance use disorders. We support social inclusion and the full participation of consumers and family members to achieve fuller lives in communities of their choice, where they can live, learn, love, work, play and pray in safety and acceptance.



Alameda County Strategic Vision

"Our County is rich with diversity. Our communities are from diverse ethnic and cultural backgrounds, economic status and lifestyles. We celebrate our differences and appreciate our commonalities. We support and encourage the building of healthy communities where individuals, children and adults can thrive and can be all they can be. We do this by protecting the general public health, providing place/population-based services, protecting vulnerable populations, and providing a safety net for families/individuals and assistance towards self-sufficiency."

Alameda County Board of Supervisors, 2008

Foreword from County Leadership

Asian Americans, Native Haiwiians, and Pacific Islanders (AANHPI) are incredibly diverse in ethnicity, language and in their historical experiences in the United States. As many as 43 different ethnic groups have struggled as immigrants, refugees, asylees or American-born Asian Americans to overcome prejudice and discrimination on the path to achievements ranging from the building of the first transcontinental railroad to innovations in medicine and technology.

The 2014 Census found that there are 6 million people who identify as AANHPI living in California and over one in four Alameda County resident's identity as AANHPI.

AANHPI communities have many protective factors that support mental health and wellbeing, such as strong family connections and cultural practices that promote balance for better health and wellbeing. However, people from AANHPI communities, especially those who have more recently immigrated to the US, may be less likely to seek mental health support than the general population.

Unfortunately, this national and statewide trend of underutilization of mental health services is also an issue here in Alameda County. As an example of this, although more than 25% of AANHPIs are eligible for mental health services here at Behavioral Health Care, less than 2% currently access mental health services.

As the Deputy Director of Alameda County Behavioral Health Care Services, I am hopeful that this utilization report will enable us to create dialogue and action regarding solutions to reducing barriers to services, which will increase access to mental health services and ultimately increase our AANHPI communities overall health and wellbeing.

Thank you to everyone who has contributed to this report. Your participation, time, effort, collaboration and partnership has been greatly appreciated. We look forward to advancing the recommendations listed in this report.

James Wagner, LMFT/LPCC, Deputy Director
Alameda County Behavioral Health Care Services

As the Alameda County Behavioral Health Care Services' Ethnic Services Manager, I am collectively working with our department to address the mental health disparities that exist among our racial, ethnic, cultural and linguistic populations.

Mental Health services to all groups through BHCS County providers are monitored and measured through the overall system-wide penetration rate. Over the past five years, the Medi-Cal beneficiaries have increased while those served have remained relatively unchanged. The penetration rates among our Asian American population remains the lowest and yet the highest number of Medi-Cal beneficiaries. If we assume about the same percentage of Asian American Medi-Cal beneficiaries require mental health services, then we are falling behind in the provision of that care. While an increase in Medi-Cal beneficiaries and decreased in individuals served does not necessarily imply all recipients require mental health services, it does suggest an increase in more services could benefit the Asian American population.

The Office of Ethnic Services and the BHCS system of care remains committed to providing culturally and linguistically appropriate services to the Asian American community and will work to identify and rectify strategies and outcomes that do not address the efficacy of programs and services.

The OES is also partnering with the Pacific Islander (PI) Task Force to take a deeper and critical examination of the challenges and needs of their community and disaggregate data in an effort to uplift the PI's specific needs.

Javarré Cordero Wilson, MPH |Ethnic Services Manager
Office of Ethnic Services | Alameda County Behavioral Health Care Service

The Asian American, Native Hawaiian, and Pacific Islander (AANHPI) population consists of more than 49 ethnic groups and 100 languages and dialects. This diverse community ranges from Asian Americans, long term East Asian immigrants, Southeast Asian refugees, and emerging populations throughout regions of Asia. Their culture and needs differ extensively from one another.

In Alameda County, the AANHPI population represents more than thirty percent of county's total population and is the fastest growing ethnic group. Although more than 25% of API are eligible, less than 2% currently access mental health services. AANHPIs are utilizing mental health services at an alarmingly low rate.

Alameda County Behavioral Health Care Services (ACBHCS) has commissioned this AANIPI Utilization Report to better understand the reasons for the AANHPI disparity in accessing and utilizing mental health services. AANHPI consumers, family members, and community based providers gave extensive feedback through focus groups and individual interviews. This report includes a review of community based reports, and overall literature review on the AANHPI community and mental health services. In addition, ACBHCS analyzed the current trends of AANHPI utilization of mental health services within the county mental health system, which is also included in the report.

As the ACBHCS Senior Planner for Mental Health Services Act (MHSA), I will use this report as a strategic guide for future planning of MHSA programs that address AANHPI disparity and improve mental health services for community members. This report will discuss ways ACBHCS will respond to this need. MHSA Innovation monies will fund unique community based strategies and Prevention and Early Intervention (PEI) funds will increase collaboration with community based providers to address language needs and provide holistic, cultural responsive interventions to the AANIPI community. I hope this report will provide the information and data to inform and guide providers, involve AANIPI stakeholders, increase collaborations, and improve necessary services and supports to the API community.

Linda Leung Flores, MSW|Senior Planner
Mental Health Services Act (MHSA) | Alameda County Behavioral Health Care Services

II. Methodology

ACBHCS contracted three parties through a request for proposal (RFP) to gather the information in this report: (1) Rocco Cheng and Associates (RCA) comprising of Dr. C. Rocco Cheng and his associates from Alameda and Los Angeles counties; (2) Dr. Rose Wong of California State University East Bay; and (3) Dr. Amy Lam and Mr. Sean Kirkpatrick. Due to different terms being used across varied literature studies referenced in the review, API and AANHPI (Asian American, Native Hawaiian, and Pacific Islanders) will be used interchangeably in this report.

The current state of mental health service utilization by AANHPI communities in Alameda County were studied between November 2016 and March 2017 via four approaches:

1. Literature review:

RCA reviewed nation-wide and statewide literature regarding the state of mental health for AANHPI and the utilization of mental health services by AANHPI members within the Bay Area and Alameda County.

2. Consumer focus groups:

RCA conducted 15 focus groups with consumers and family members of diverse backgrounds and one additional focus group with service providers to better understand the barriers for mental health utilization and brainstorm relevant strategies to improve the use of mental health services. Consumers and family members focus groups included members from the following communities: ACBHCS API Pool of Consumer Champions (POCC), Burmese, Cambodian, Chinese consumers, Chinese family members in the Alameda County South Chapter of the National Alliance on Mental Illness (NAMI), Farsi, Korean elders, Mien, Mongolian, Samoan, Samoan faith leaders, Vietnamese, youths, female youth refugees, college students.

3. Interview of key providers and stakeholders:

Dr. Rose Wong conducted 27 interviews with members of diverse agencies to learn about barriers and possible strategies for improving mental health utilization. These agencies included: Afghan Coalition, Afghan Psychological Association of America, Alzheimer's Association, Asian Health Services (AHS), Burmese Refugee Family Network, Center for Empowering Refugees and Immigrants (CERI), City of Fremont, Community Health for Asian Americans (CHAA), Dig and Demand: Queer Diasporic Vietnamese Artists for Justice, Diversity in Health Training Institute, East Bay Innovations, Filipino Advocates for Justice (FAJ), International Rescue Committee, Korean Community Center of the East Bay (KCCEB), Multi Lingual Counseling Inc., NAMI-Alameda County South, Pacific Islander consultant, Pacific Islander Task Force, Partnerships for Trauma Recovery, STARS Community Services, Washington Hospital, and Wellness in Action.

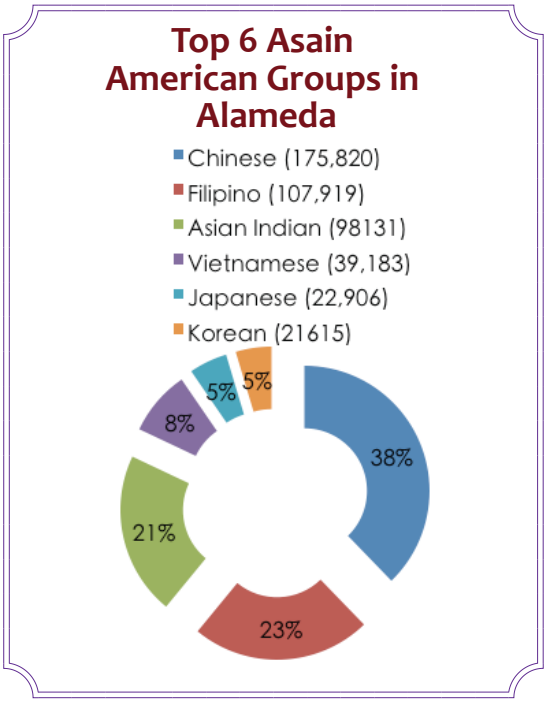
4. Community Report Analysis:

Dr. Amy Lam and Mr. Sean Kirkpatrick conducted an extensive review of 120 community reports and prepared a summary report on barriers, utilization, and recommendations for mental health services in AANHPI communities.

III. Alameda County Asian and Pacific Islander Demographic Overview

AANHPIs are quite diverse and most of them are immigrants. They account for 58% of foreign-born population in Alameda.

Alameda County is home to many Asian American, Native Hawaiian, and Pacific Islander (AANHPI) individuals and families, and the AANHPI population has grown significantly in the county over the years. According to the U.S. Census data, there was a 49% increase in the Asian population and a 51% increase in the NHPI population between 2000 and 2015 (not including AANHPI in combination) within Alameda County. As of 2015, the total population in Alameda County was 1,584,983, with 32% of the total population identifying themselves as Asian alone or in combination by selected groups, and approximately 1.5% identifying as NHPI alone or in combination by selected groups.



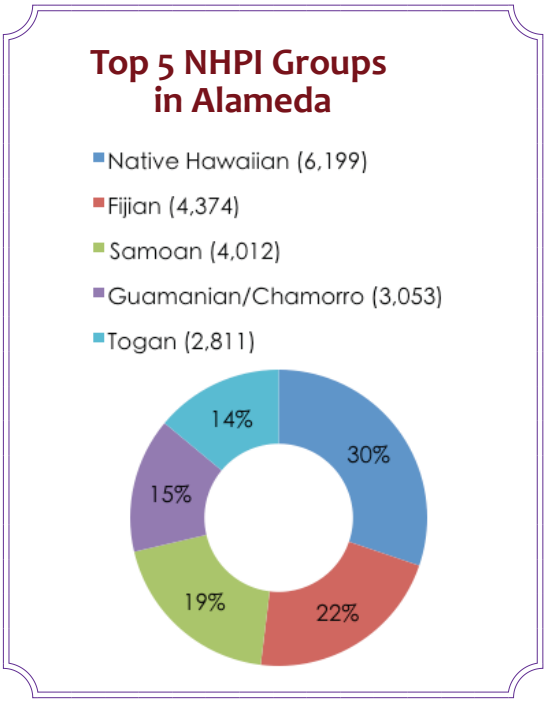


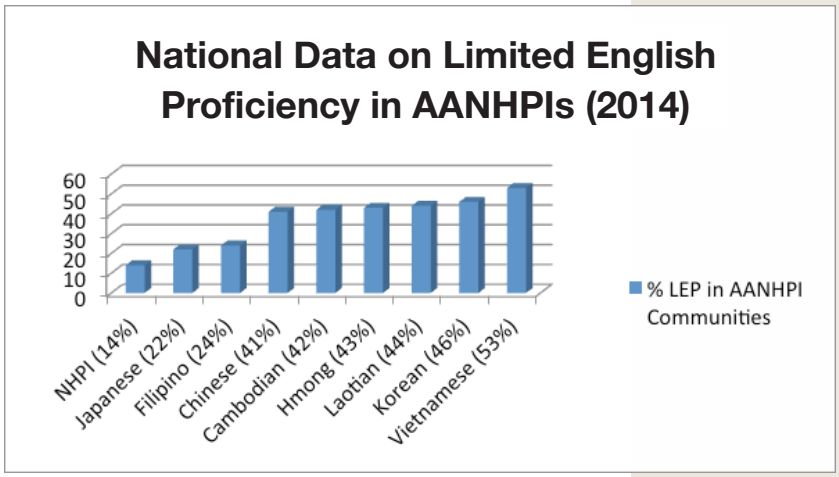
Table I provides a list of AANHPI groups that were included in the 2015 Census data for Alameda County. We should note that the group listed in table I is not an exhausted list of AANHHPI communities in Alameda County. The other important fact about AANHPI is that most of them are immigrants. **The 2015 Census indicated that AANHPI accounted for 58% of the foreign-born population in the county.** In addition, 19% of the households in Alameda County speak API languages, and of those households, 29% are limited English-speaking households.

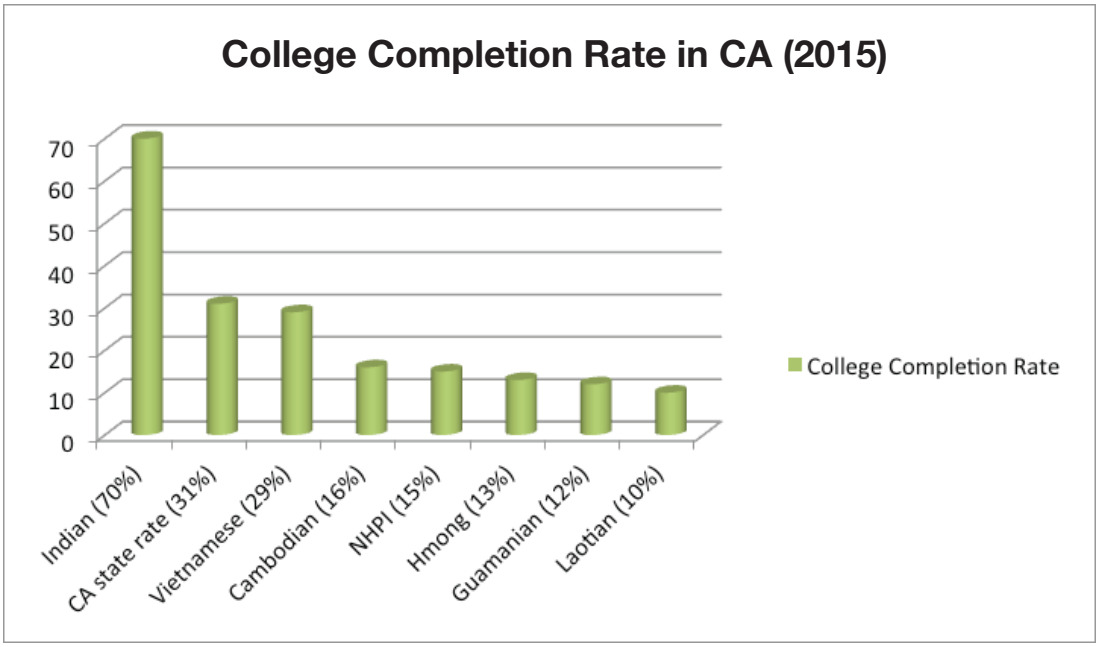
Given the diversity within the AANHPI populations, it is to be expected that there would be many differences across its ethnic subgroups. These differences could be observed in terms of language, culture, history, immigration patterns, religion, spirituality, traditions, acculturation, and socioeconomic status, just to name a few. While AANHPI (or API) is commonly used as one grouping in various governmental documents and reports, we should be mindful of the huge heterogeneity within the AANHPIs. For example, **many advocates from the NHPI communities remind the fact that their cultures and heritages are quite different from the Asian Americans and should be considered as separate groups when looking into behavioral health needs and strategies.** Many NHPI representatives advocate that they should be considered as separate from Asian Americans when looking into behavioral health needs and strategies.

Many NHPI representatives advocate that they should be considered as separate from Asian Americans when looking into behavioral health needs and strategies.

The heterogeneity among AANHPIs was also reflected in the differing rates of limited English proficiency (LEP) and the highest educational level attained across subgroups. We can expect a similar trend in Alameda County as we observe it in the nation.

Nationally, while 14% of NHPIs reported limited English proficiency, the proportion of Asians with LEP ranged widely from around 22-24% for Japanese and Filipinos; around 41-46% for Chinese, Cambodians, Hmong, Laotians, and Koreans to 53% for Vietnamese (Ramakrishnan & Ahmad, 2014). In terms of educational attainment, about 70% of Indian adults who are 25 years and older have a college degree, while several AANHPI ethnic groups fall below the state average (31%) of adults 25 years and older with a college degree, including Vietnamese (29%), Cambodian (16%), Hmong (13%), NHPI (15%), Laotian (10%), as well as Guamanian/Chamorro and Samoan (12%) (The Campaign for College Opportunity, 2015).





Contrary to the common stereotype of the model minority, many AANHPIs do struggle with poverty. Of the individuals who live below the poverty level in Alameda County, 9.4% of them identified as Asian alone and 11.9 % identified as NHPI alone in the 2015 Census. Specifically, poverty rates for many Southeast Asian groups are equal or higher than the state average of 23%, including Hmong (42%), Cambodian (33%), Laotian (31%), and Burmese (23%), while other AANHPI subgroups enjoy much lower rates of poverty than the state average, including Indian (6%), Taiwanese (6%), and Japanese (7%;The Campaign for College Opportunity, 2015)

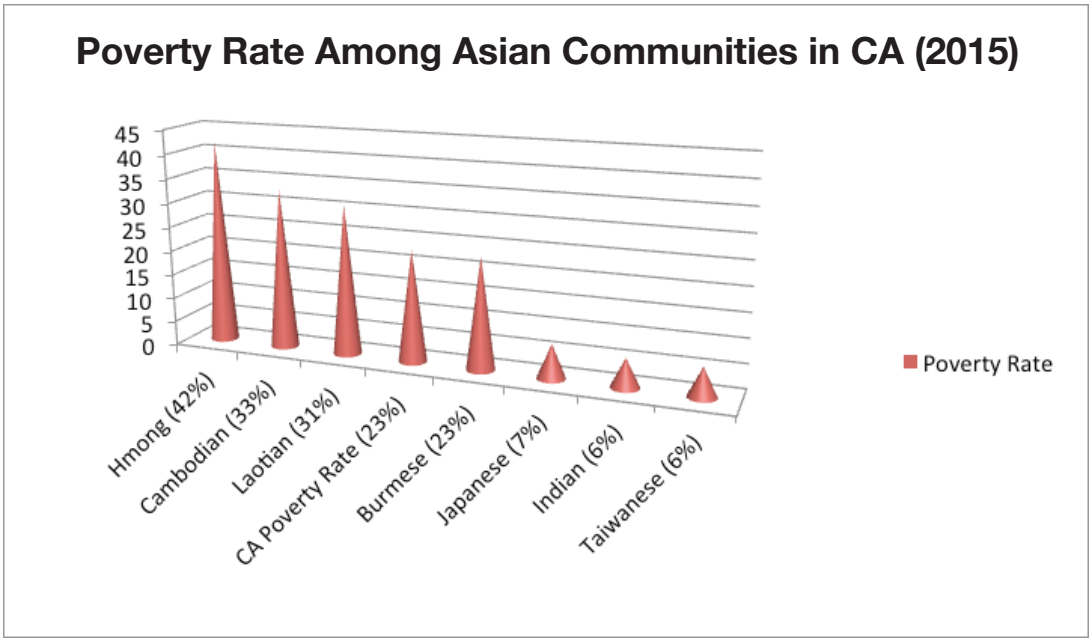


Table I: 2015 Census in Alameda County
Asian Population

Subject	Alone	% of the total population in Alameda County	Alone or in combination with one or more other categories of same race	% of the total population in Alameda County
Total:	439,055	27.7%	507,029	31.99%
Chinese, except Taiwanese	149,683	9.44%	170,413	10.75%
Filipino	88,349	5.57%	107,919	6.81%
Asian Indian	93,212	5.88%	98,131	6.19%
Vietnamese	33,949	2.14%	39,183	2.47%
Japanese	13,100	0.82%	22,906	1.45%
Korean	18,428	1.16%	21,615	1.36%
Afghani *	8,958	*0.56%		
Iranian*	6,220	*0.39%		
Taiwanese	5,088	0.32%	5,407	0.34%
Cambodian	4,210	0.26%	5,176	0.33%
Pakistani	4,751	0.29%	5,102	0.32%
Laotian	3,960	0.25%	4,492	0.28%
Burmese	2,249	0.14%	2,962	0.19%
Thai	2,180	0.14%	2,815	0.18%
Indonesian	1,298	0.08%	2,336	0.15%
Nepalese	1,699	0.1%	1,763	0.11%
Mongolian	1,109	0.07%	1,343	0.08%
Sri Lankan	796	0.05%	928	0.06%
Hmong	708	0.04%	737	0.05%
Bangladeshi	467	0.03%	539	0.03%
Malaysian	314	0.02%	518	0.03%
Bhutanese	103	0.006%	332	0.02%
Okinawan	0	0	96	0.006%
Other Asian, specified	131	0.008%	157	0.01%
Other Asian, not specified	1,507	0.09%	12,159	0.77%
NHPI Populations				
Total:	13,760	0.87%	24,698	1.56%
Native Hawaiian	2,326	0.15%	6,199	0.39%
Fijian	3,245	0.2%	4,374	0.28%
Samoan	2,846	0.18%	4,012	0.25%
Guamanian or Chamorro	1,500	0.09%	3,053	0.19%
Tongan	2,176	0.14%	2,811	0.18%
Marshallese	141	0.009%	141	0.009%
Other Polynesian	126	0.008%	177	0.01%
Other Micronesian	125	0.008%	154	0.01%
Other Melanesian	18	0.001%	18	0.001%
Other PIs, not specified	1,030	0.06%	3,759	0.24%

*Afghani and Iranian data accessed from different source and did not have complete information.

IV. AANHPI revalence

AANHPI females aged 15 to 24 ranked second among all racial groups in suicide rates

Asian Americans are often considered the "Model Minority" in the United States: hard-working, high-achieving academically, and successful. With such stereotypes, some may expect low prevalence rates for mental illnesses and low utilization rates of mental health services among Asians. However, a closer look at the data suggests a different picture.

The 2000 Census and the California Department of Mental Health showed that prevalence rates of mental illness for Asian Americans were similar to the general population when looking at AANHPI children, youths, and transitional age youths (TAYs, age 16 to 25 year old). For example, 7.18% of Asian youths and 7.67% of Pacific Islander youths were estimated to have a serious emotional disturbance, compared to 7.51% of the total youth population in California. **The prevalence rate is similar in Alameda County, where 6.95% of Asian youths and 7.53% of Pacific Islander youths were estimated to have a serious emotional disturbance, compared to 7.13% of the total youth population in Alameda County.** Given similar prevalence rates of emotional disturbances, it is helpful to examine the data on the leading causes of deaths for AANHPIs. In 2007, suicide was the third leading cause of death for AANHPIs ages 10 to 14 (Center for Disease Control). Moreover, AANHPI females aged15 to 24 ranked second among all racial groups in suicide rates, at 4% in 2006 and 3.8% in 2007. Suicide is also alarmingly common among NHPI youths. The 2009 CDC national survey showed that 19.2% of NHPI adolescents had suicidal ideations, 13.2% made suicide plans, and 11.9% attempted suicide in the previous year (Asian & Pacific Islander American Health Forum, 2010). It is important to look at the data on emergency services to better understand help-seeking behaviors in the context of mental health service utilization. Among children receiving mental health care from California's county systems between 1998 and 2001, AANHPI children were more likely than White children to use hospital-based crisis stabilization services. This suggests that AANHPI caretakers tended to postpone treatment for mental illness until it has reached a critical level and became a crisis. Delayed help-seeking may be due to stigma, mistrust of the system, and/or language barriers (Snowden, Masland, Libby, Wallace, & Fawley, 2008).

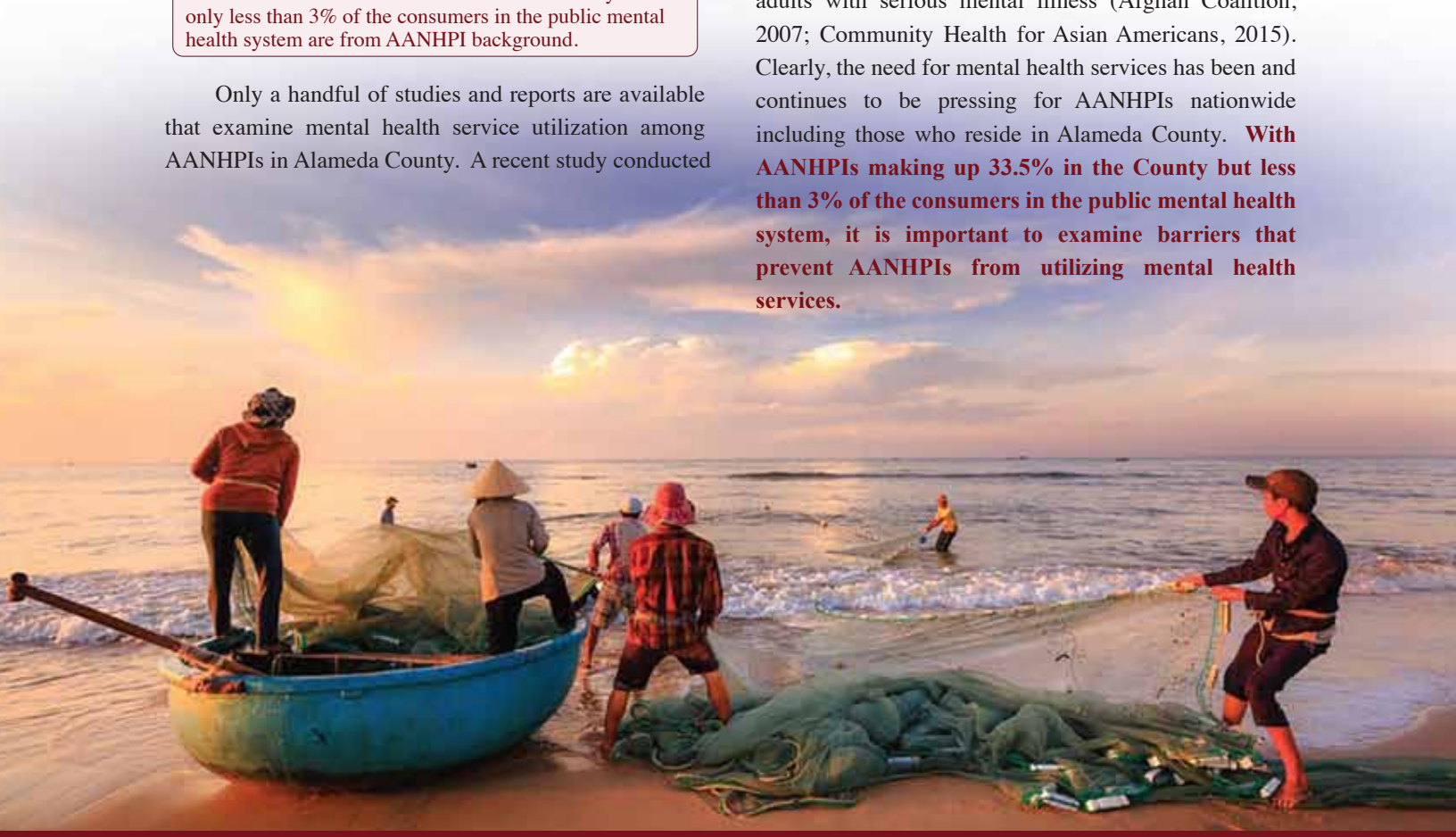
Despite comparable or higher prevalence rates of mental illness, AANHPIs continue to utilize mental health services at a low frequency.

For AANHPI adults and older adults, 5.6% of Asian adults and 7% of Pacific Islanders adults were estimated to suffer from serious mental illness, compared to 6.25% of the total adult population in California (California Department of Mental Health, 2000). In 2007, suicide was the second leading cause of death for individuals aged 15 to 34 (Center for Disease Control). Additionally, the Center for Disease Control data showed that compared to all other racial groups, AANHPI women aged 65 and over consistently had the highest suicide rate in 2006 (6.9%v.s. non-Hispanic White ranked second at 4.3%) and in 2007 (5.2% vs. non-Hispanic White ranked second at 4.4%). The 2000 Census estimated that 6.1% of the total population in Alameda County were experiencing a serious emotional disturbance or serious mental illness at one time. Another report estimated that **5.39% of Asian adults and 6.79% of Pacific Islanders adults suffered from a serious mental illness compared to 5.76% of the total adult population in the county** (California Department of Health Care Services, 2000).

Despite comparable or higher prevalence rates of mental illness, AANHPIs continue to utilize mental health services at a low frequency. A study conducted in 2011 found that Asian Americans who had attempted suicide were less likely to seek help and less likely to perceive a need for help when compared to Latinos (Chu, Hsieh, & Tokars, 2011). The authors of the study suggested that Asian Americans with suicide ideations may underestimate the severity of their condition or have different ways of understanding or coping with suicidal ideations. Another study focusing on Cambodian immigrants also revealed low rates of service utilization. Marshall et al. (2006) interviewed 339 Cambodian immigrants in Long Beach diagnosed with PTSD, major depression disorder, or alcohol use disorder, and found that while 70% of interviewees sought help from Western medical care providers for emotional or psychological problems in the past 12 months, only 46% turned to mental health providers for services. The need for mental health services is apparent, yet those who are in need are not gaining access or receiving proper care.

There are 33.5% of AANHPIs in Alameda County but only less than 3% of the consumers in the public mental health system are from AANHPI background.

Only a handful of studies and reports are available that examine mental health service utilization among AANHPIs in Alameda County. A recent study conducted by the Korean Community Center of the East Bay (KCCEB) and the Health Research for Action (HRA) center at UC Berkeley examined the health and social needs of Korean communities in the five counties of the Bay Area including Alameda County (Ivey et al., 2016). The results revealed that **13% of their survey participants reported serious psychological distress (SPD) and 28 % were at a high risk of developing SPD. Many participants also reported that their emotional distress had severely or moderately interfered with their work, daily, and social functioning.** Nevertheless, of those who reported impaired functioning due to SPD, **only 9% felt that they might need help and only one respondent actually sought help from healthcare professionals** (Ivey et al., 2016). Other reports based on data from Alameda County have raised the issue of mental health disparities in local underserved communities, such as refugees, recent immigrants, and older Asian adults with serious mental illness (Afghan Coalition, 2007; Community Health for Asian Americans, 2015). Clearly, the need for mental health services has been and continues to be pressing for AANHPIs nationwide including those who reside in Alameda County. **With AANHPIs making up 33.5% in the County but less than 3% of the consumers in the public mental health system, it is important to examine barriers that prevent AANHPIs from utilizing mental health services.**



V. Challenges

Overview

A person who has a 'mental health' condition may be excluded from social interactions with their community.

Based on interviews with providers and stakeholders, Dr. Rose Wong's report revealed 14 major barriers to the utilization of mental health services in the AANHPI community. They can be grouped into three general themes:

Social and cultural factors:

1. Stigma, shame, & denial of mental illness
2. Lack of understanding and education about mental illness, symptoms, and treatment
3. Difficulties adjusting to new environment and language and complex mental health system
4. Lack of trust in mental health providers and organizations
5. Poverty, difficulties accessing mental care, and low priority for mental health services while experiencing the need for multiple services
6. Lack of mobility, transportation, time, or family support that lead to extreme isolation

Service provision gaps:

7. Culturally insensitive services that do not integrate ethnic healing practices & culturally based mental health and wellness constructs
8. Insufficient providers with appropriate linguistic/cultural skills available in smaller communities
9. Insufficient providers with appropriate linguistic/cultural skills when clients seek help
10. Insufficient interpreters available to aid service delivery and insufficient training in mental health for interpreters

Lack of funding support for quality services:

11. Health insurance coverage problems and difficulty finding available providers
12. Lack of affordable mental health services
13. Low resources to perform outreach and bridge communities to services
14. Dependence on MediCal standards, which prevents increments to the provider pool and delivery of services.

Stigma

"… people don't go to psychological services because they feel they are not mentally ill"

Stigma was significant both at a personal and social level for first- and second-generation South Asian college students (Loya, Reddy, & Hinshaw, 2010). Compared to Caucasians, they reported more negative attitudes towards mental illness, and greater reluctance to seek help. They are also more likely to distance themselves socially from those with mental illnesses.

A 2005-2006 study on older Korean Americans in Florida illustrated how stigma deterred those in need from seeking help (Jang, Kim, Hansen, & Chiriboga, 2007). Out of 472 foreign-born Korean Americans aged 60 and over, 34% reported probable depression and 8.5% reported suicidal ideation. However, only 6.5% have contacted mental health professionals in the past. This might reflect their attitudes towards mental illness, as 71% considered depression a sign of personal weakness and 14% stated that mental illness would bring shame to the family. Even when an AANHPI individual is able to overcome stigma and seek help, approaching mental health providers may be one of the last resorts after exhausting the option of consulting community faith leaders, family members, friends and other primary care providers.

Cultural Barriers

The AANHPI communities understand mental illness and seek help differently from typical Americans. The concept of 'mental health' or 'mental illness' is foreign or inexistent to many AANHPI members. They avoid talking about myths and misconceptions associated with mental illness due to fear of stigma and discrimination. Many believe that symptoms of mental illness are to be endured as part of life rather than effectively treated.

Differences in culture and worldview play an important role in the low utilization of mental health services. Mental health interventions are typically derived from a Western approach (e.g., "talking cure") and does not necessarily match the culture or worldview of the community member. Interventions that are not understood and accepted by AANHPI consumers will likely be utilized less often (e.g., high attrition rates) and less effective when utilized (e.g., poorer outcomes).

Individuals conceptualize their experience in varied ways based on their cultural and spiritual worldviews. In some cultures, mental illness may be connected to spiritual beliefs such as "karma" or spiritual phenomena (e.g., being possessed). They may turn to faith leaders to help them alleviate their pain or suffering and avoid going to mental health professionals for help due to stigma. They may use spiritual practices such as prayers or rituals and ceremonies to help them overcome their difficulties.

AANHPIs also tend to present their mental health problems as physical symptoms to their primary care providers rather than seek help for emotional difficulties (Zhang, Snowden, & Sue, 1998). However, primary care providers do not typically specialize in working with people who have mental health issues and may lack the proper tools and training to diagnose or treat mental illnesses.

Such strong reluctance towards help-seeking could, in turn, result in situations where mental health services are sought only when problems become severe (Chow, Jaffee, & Snowden, 2003). **Across many AANHPI immigrant and refugee communities, the words "mental health" are often associated with severe mental illness** (e.g., crazy, insane, abnormal thinking). In some AANHPI cultures (e.g., Chinese), mental illness is attributed to social circumstances (e.g., trauma events, loss of a family member), while in other cultures (e.g., Pacific Islands), mental illness is thought to be caused by a person's (or their family's) negative thoughts and intentions towards others in their community. Regardless of its cultural etiology, **the perception that mental illness is associated with someone in a "crazed" state means that for many individuals from AANHPI communities, mental health is a highly stigmatized topic.** Not surprisingly, the taboo nature of mental illness has a negative impact on help-seeking and the ability to utilize mental health services for AANHPIs. **Therefore, non-stigmatizing psycho-education will be essential to address cross-cultural differences in understanding mental illness and increase acceptance of Western interventions.**

The feedback below illustrates how mental health is viewed by several focus group participants:

"We don't normally go to psychologists or psychiatrists because Thai people regard the services to be for severe mental illness. Thai people don't go to psychological services because they feel they are not mentally ill."

"Within the Bay Area Himalayan communities, a person who has a 'mental health' condition may be excluded from social interactions with their community."

"Focus groups with Pacific Islander men identify cultural values for men to be proud warriors, which leads to their perception that being sick is a sign of weakness."

"The potential to be shunned in various API cultures that value interdependence and collectivism is often unbearable and causes deep shame for those with mental health issues."

Pacific Islander men identify cultural values for men to be proud warriors, which leads to their perception that being sick is a sign of weakness.

Language barriers

Asian households have the highest levels of linguistic isolation in Alameda County.

More than half of Asians in California are foreign-born and many were recent immigrants (Ponce et al., 2009). As a result, **a significant portion (36%) of the Asian population had limited English proficiency (LEP), making it difficult for them to seek mental health services.** In Alameda County, the pattern holds similar and older adults seem to experience the most difficulties with language barriers. A study of 17,000 Californians aged 55 and older (Sorkin, Pham, & Ngo-Metzger, 2009), of which 1,215 were Asians, showed that Asians were more likely to utilize mental distress but less likely to use mental health services compared to Caucasians. Moreover, 81% of Asians surveyed were foreign-born and 39% had LEP. Authors of the Sorkin et al. (2009) study suggested that language barriers might increase an individual's sense of isolation, decrease social support, and result in less access to care.

While a multilingual and culturally competent workforce may help target linguistic difficulties, there continues to be a shortage of workers who are well-versed in the diverse languages, cultures, and unique skill sets required to navigate the wide range of challenges posed by a heterogeneous Asian population. For example, training programs for mental health professionals typically do not teach in languages other than English nor do they provide additional resources for students who may wish to work with an Asian population.

"Anywhere we go – we worry about interpretation because sometimes they don't provide interpreters. Everywhere we go, we have to get someone to go with us and translate for us."

Interpreters are sometimes used to communicate with clients of poor English proficiency. The quality of the interpreter matters. Interpreters are often not sufficiently trained in mental health concepts and terminology. **Similarly, clinicians who have not been trained in the use of interpreters may make mistakes that reduces treatment efficacy.** For example, they may have trouble establishing rapport and trust with clients when they speak to the interpreter who shares their language

instead of speaking directly to the consumer. In surveying 2,715 LEP Asians at 11 community-based health centers serving large Asian populations across the U.S., perceived quality of the interpreter was strongly associated with the quality of care perceived by patients, while receiving interpretation by family members and untrained staff was associated with lower satisfaction (Green et al., 2005). Therefore, **it is important to provide rigorous training for interpreters, and for clinicians to work with interpreters, instead of depending on family members of clients for translation.**

Clinicians require training to effectively utilize interpreters while maintaining the integrity of their service.

More languages are used in Alameda County than there are available interpreters. Language access impacts children and youth services where parents require language assistance to consent to their child receiving mental health services and to adequately support the treatment and case management plans of their children. One report states, "According to the Centers for Disease Control, as of 2007, there are over 100 languages other than English spoken in Alameda County. According to the California Department of Education, **53 languages were spoken by English-language learners in the K-12 public school systems in Alameda County in 2008-09. On the other hand, Alameda Health System offers interpretation services for only 26 languages."**

Communities reported a high preference for and greater satisfaction with face-to-face interpretation compared to telephone interpretation, as body language or visual social cues may help communicate nuances and clarify interactions. Most uses of telephonic interpretation occur in primary care and legal support settings, including support for domestic violence. Despite being the only option for many languages, community reports revealed dissatisfaction with interpretation done over the phone.

On the other hand**, individuals from small communities are often reluctant to utilize a face-to-face interpreter due to concerns about confidentiality and privacy.** This speaks to the strong stigma towards

mental health, and communities' limited awareness of or confidence in the ethical and legal boundaries that interpreters are trained to keep. In some instances, these concerns may be warranted when untrained people are utilized for interpretation services.

The feedback below from focus group participants illustrates the challenges of working with interpreters:

"Everywhere we go – social services or the hospital or anywhere we go – we worry about interpretation because sometimes they don't provide interpreters. Everywhere we go, we have to get someone to go with us and translate for us."

"Asian households have the highest levels of linguistic isolation in Alameda County. Language and cultural capacity of service providers was also the most frequently mentioned issue in focus groups and interviews conducted with providers."

"One challenge is that there are far more API languages represented in the County than there are interpreters."

ACBHCS has invested in programs such as ACCESS to provide language-matching access to targeted unserved and underserved AANHPI communities since 2010. However, paraprofessional providers in these programs are taxed with navigating services in multiple systems (e.g., schools, health care settings, social services, etc.), despite typically working in a part-time capacity. This adds to the probability of overwork, burn-out, and poor professional boundaries, which in turn impact their ability to provide quality support.

In sum, the need for appropriate linguistic and cultural services is multi-faceted. It includes, and is

not limited to, linguistic support for current mental health service workers (e.g., supervision in appropriate languages)**, recruitment of more multi-lingual workers, and provision of appropriate translation services** (e.g., translators trained in mental health terms and concepts; mental health service workers trained in the use of translators).

Service Availability

AANHPI individuals may find mental health services to be inaccessible due to the shortage of a competent, qualified workforce that is both bi-cultural and bi-lingual.

The language diversity in AANHPI communities makes it difficult for agencies to have an adequate workforce to cover all the language needs of the community. Staff or interpreters who match the culture and language of potential consumers may have limited availability as they are overloaded by demands from the community. The strain of being one of the very few service provider, advocate, and resource of a community with high needs may quickly lead to burnout, poor boundaries, and other negative consequences that further eat away at the competent workforce.

While workforce challenges directly impact service availability, the location of the service provider can add another layer of difficulty for accessing services. At times, the agency providing appropriate mental health services may not be located in the vicinity of the AANHPI community, making it harder to get services. Many AANHPI community members are dependent on public transportation for various reasons (e.g., age, immigrants who are used to public transportation in country of origin, etc.), and are unable to travel with the ease of driving. **In addition to being costly, transportation over a long distance takes a lot of time and energy, making it extremely challenging to access services regularly.**

In sum, the need for appropriate linguistic and cultural services is multi-faceted. It includes, and is not limited to, linguistic support for current mental health service workers (e.g., supervision in appropriate languages), **recruitment of more multi-lingual workers, and provision of appropriate translation services** (e.g., translators trained in mental health terms and concepts; mental health service workers trained in the use of translators). Unfortunately, these efforts may not meet the criteria for funding in mental health. Thus, many communities continue to struggle with having adequate materials and activities that are linguistically and culturally appropriate for orienting and educating community members about mental health.

For AANHPI communities, the gateway to receiving mental health support may lie in areas outside of mental health, including needs in social service, language development and/or citizenship acquisition, employment attainment and so on. If agencies only look to engage AANHPI community members through the narrow "entryway" of mental health, their success rate may be much lower than if needs in other areas are considered and integrated in outreach efforts.

Services under Underserved Ethnic Language Population (UELP) MHSA Prevention and Early Intervention (PEI) staff and SSA-funded Social Adjustment Counselors are often called upon to provide interpretation at schools, hospitals, and social service settings because of inadequate language access and service navigation

resources for LEP clients from AANHPI communities that do not meet threshold numbers for language translation to be provided. These clients include new immigrants, less common language groups, and refugees.

For new AANHPI immigrants and refugees served by the ACBHCS' UELP programs, the combination of limited providers, needs in multiple domains, and fragmented resource systems means that their UELP providers spend a large amount of their time helping clients to access basic needs across multiple systems and less time on formal mental health support or treatment. Therefore, it is no surprise that community mental health providers are often pulled to provide support related to a whole range of complex needs as part of their work.

Age-Appropriate Services:

One challenge of working with AANHPI communities is access to age-appropriate services. From conversations in the focus groups, many youths expressed the wish to have a safe space and positive role model for them to develop a positive identity and a strong sense of wellness. **Interdependence is highly valued in AANHPI families. Therefore, it would be beneficial to strengthen the family structure and use it as a source of support for promoting mental health and wellness.** Indeed, parenting support, socio-emotional development in children, bullying, and inter-generational conflict are all topics that seem to attract community members to participate in conversations and learn about mental health from a framework that focuses on prevention and wellness.

We also need to consider the specific needs of AANHPI elders and to help them deal with changes in roles and needs as they progress into the different phases of life. **Social isolation and challenges in managing transportation are just some of the issues that need to be considered when implementing programs for the elderly.** Other considerations for AANHPI elders may include a cultural understanding of their role in the community, as well as sensitivity to their acculturation process and any cultural adaptation that elders may need to make as their role is redefined within their new environment and shifting family landscape. As one focus group member reflected:

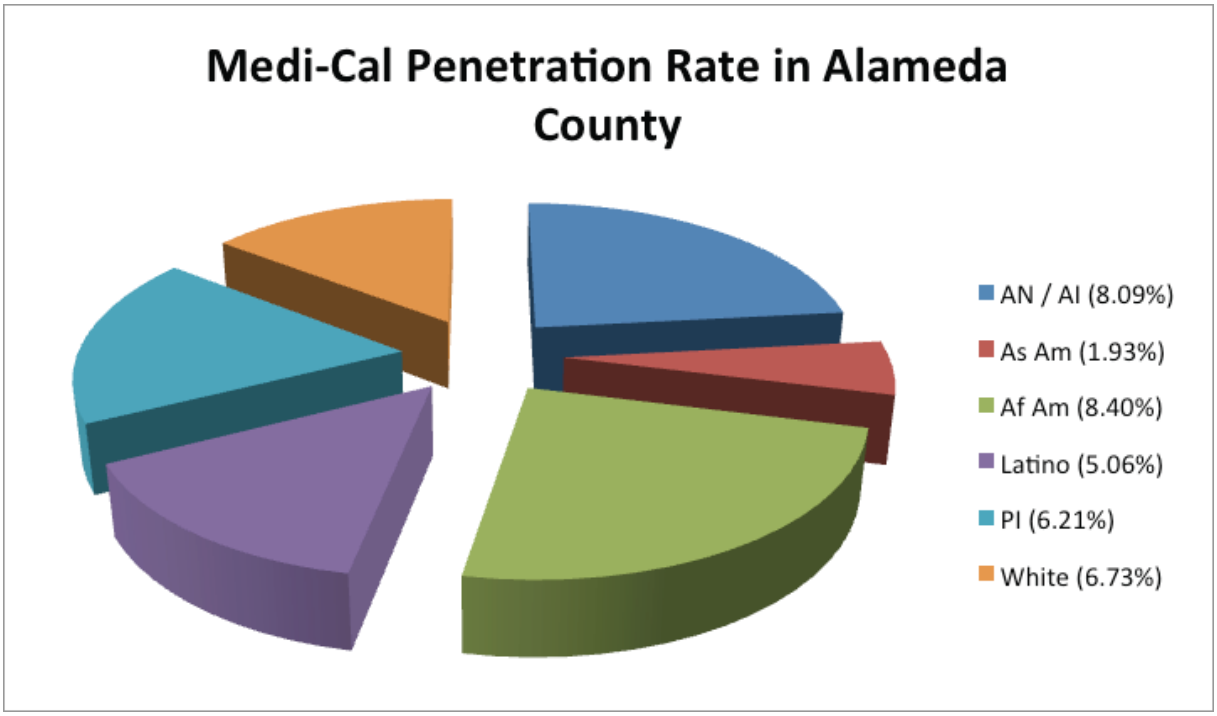
> ***"The values of protecting families, supporting community, honoring elders, and educational achievement provide strength for the communities, as well as potential pathways to overcome stigma around mental health services."***

VI. Alameda County API Mental Health Utilization Data

Due to various barriers and challenges outlined above, the mental health utilization rate is much lower in the AANHPI community than **the prevalence rate. Even when AANHPI members come through the door to receive mental health services, they are likely to drop out prematurely if the service does not make sense to them or is too difficult to access.** County service data showed a much lower rate of utilization and community penetration compared to numbers from the demographics. Here are some of the existing service data available:

For Medi-Cal penetration rate (2015-16):

Alaska Native or American Indian	8.09%
Asian American	1.93%
Black or African American	8.40%
Hispanic or Latino American	5.06%
Pacific Islander	6.21%
White	6.73%



VII. Recommendations

Children/Youth and TAY

When designing programs for children, youths, and transitional aged youths (TAY), it is important to factor in the role of peer groups, family, and school. School- and community-based programs are important and often effective when focused on the strengths and needs of the child and family. Some effective strategies include school- and community-based Wraparound services, after-school programs, parenting workshops, art/music/video projects, mentoring, and opportunities to learn about their own culture. Gender-specific programs may be helpful for engaging youths and encouraging the development of their identity. It is important to have a safe space (such as a teen center) where young people can gather and learn from positive role models about life skills and the development of a positive identity.

For youths, physical activities (e.g., walking, hiking, playing paintball, rowing) provide a natural setting to share and disclose personal information. Youths may appreciate the opportunity to connect with other young adults from the community who have been through similar challenges and can offer mentorship or advice. This is especially true as youths are often inspired by mentors and role models who have beaten the odds or risen above the challenges.

Parents and caregivers are an important population to target when attempting to improve the wellbeing of children and families. For example, a father's group was formed in the Tongan community to support men on how best to take care of their children and families. Topics of interest for the group include domestic violence, parenting tips, how to support your child in school, and how to be a good partner. Many wives were pleased that their husbands were coming together to focus on the family and looked forward to joining the group conversations as well. In other communities, it was suggested that programs addressing the needs of men (e.g., anger management, alcohol abuse, domestic violence, and recreation needs) are needed.

Other innovative programming can help to improve intergenerational cohesion within a community. SAUCE, a program by Banteay Srei (a youth development organization), is a "peer and intergenerational cooking class, where young Southeast Asian women learn about traditional recipes and herbs in traditional Southeast Asian cuisine." The focus of this program is intergenerational dialogue, where older and younger Southeast Asians connect and foster healthy relationships with one another through cooking and eating traditional foods along with sharing stories about the refugee and resettlement experience.

"Not only do the young women learn to cook, listen to stories, and share their experiences of growing up in Oakland with each other, they also learn and explore different herbs, spices, fusion recipes, healthy foods and sustainable living."

Adults and Older Adults

For adults and older adults, we need to put in extra effort in ensuring that the program design is relevant culturally and linguistically. It is necessary to have appropriate outreach, engagement, and educational materials, as well as professional staff with native language capacity and cultural abilities. **Given that stigma is one of the major barriers for seeking mental health help, it is important to hold anti-stigma campaigns** involving public figures, conduct non-stigmatizing educational workshops about mental health and mental illness, and collaborate with agencies or programs providing services for needs other than mental health. Some of these programs may include, but are not limited to: English as Second Language, employment training, social services such as citizenship class and application, social security and Medi-Cal application, nutrition/health and wellness workshops, as well as programs about traditional culture and art.

Similarly, creating community connections within a group setting can help validate and normalize symptoms of the Post Traumatic Symptoms Disorder (PTSD) that many clients experience. One unique way that Center for Empowering Refugees & Immigrants (CERI) has integrated psychiatry in their groups is to have a community day event where members socialize with each other while consuming food, coffee, and tea, and as they wait to see the psychiatrist. This strategy works especially well for the CERI community where the group cohesion is very strong.

Capacity Building

Many agencies in the AANHPI community are relatively small in size and capacity despite the amount of services they provide and their level of importance to the community. There are limited resources available to the AANHPI community in spite of their great need. **Alameda County has several AANHPI communities with less than 3,000 individuals who experience high needs across multiple domains. The task of supporting these smaller communities and the agencies that serve them is vital.** Therefore, capacity-building is a critical issue to consider.

At the individual provider level, it is essential that providers develop skills that help to empower the community and fully utilize existing resources. For agencies, we need to demonstrate cultural competence in several capacities, including the ability to educate the community on mental health issues, to collaborate with other community organizations such as schools and primary care providers, to train professionals and paraprofessionals on cultural competence, and to develop a future workforce (e.g., psychologists, mental health providers, interpreters) that is culturally competent.

With sufficient support from various systems, all these capacities can be developed to meet the needs of the AANHPI community, and can significantly contribute to its empowerment. For example, it was documented that some Cambodian temples housed the mentally ill. Given that spirituality is an important cultural component reported by the community, the system could provide resources for the mental health service providers, the family members, and the temples to work together to take care of those in need.

Furthermore, the system can also foster capacity-building by encouraging meaningful involvement by the community in the policy-making process to ensure that policies adequately and effectively address the needs of the AANHPI community. This may include a leadership program for consumers so they can be the advocates and spokespeople for the consumers. The existing Pool of Consumer Champion (POCC) is a good example of a program that fosters consumer leadership. More effort can be invested in nurturing mental health advocates and leaders from diverse AANHPI communities. One effective way to do so would be to create and support infrastructures that make good use of existing strengths and resources within the AANHPI communities. For example, local social and recreational programs may appear at first to have little direct relevance to mental health, but their non-stigmatizing nature can help engage individuals and communities, and provide social support in a way that fully utilizes limited resources and strengths of the community. Lastly, support for a central resource center will be a cost-efficient way to take advantage of technology and resource-sharing to facilitate outreach and linkage.

VIII. Short term / Long term Goals and Recommendations

With the challenges identified above, we also found some strategies that may help improve the low utilization of mental health services experienced by AANHPI members. Here are some likely strategies:

Community Provider Interpreter Team

While access to resources may be limited to different staff, a collaborative provider team can bypass these limitations. **The provider team may include community mental health workers, interpreters, and clinicians. In addition to mental health interventions that are provided by clinicians, we have established that outreach, engagement, and education are very important steps to take when working with AANHPI communities.** Hence, community mental health workers or health navigators are well-positioned to conduct outreach, engagement, and education with the target community. While doing outreach and engagement activities, it will be important to invest sufficient resources to ensure that outreach efforts are culturally and linguistically appropriate. At the very least, this will include documents and marketing materials in the native AANHPI language. These outreach, engagement, and education efforts are essential to raise the awareness of mental health, and to reduce stigma and discrimination related to mental illness. If the community mental health worker does not speak the language of the target community, it will be important to work with interpreters. Here, **the interpreters should be properly trained in mental health concepts so that they will be able to interpret the communication between consumers and mental health workers effectively. Not only are trained interpreters critical in outreach and engagement efforts, they are also essential to clinical interventions.**

Mental Health Interpretation Training

As indicated above, interpreters are crucial in reaching out to and working effectively with AANHPI communities, and should receive proper training and support. Currently, the mental health workforce has a long way to go before becoming culturally and linguistically responsive towards AANHPI needs. Therefore, it is important to expand the workforce by including community members who can serve as interpreters for mental health services. **Trained community members can become great assets to serve the community with their shared cultural experience and language skills. They are often more familiar with the challenges and struggles that consumers and family members are going through. They are also familiar with the community and it is much easier for them to establish a trusting relationship, given similar backgrounds and experiences.**

One of the greatest lessons learned from the perspective of the trainers was that interpretation must be viewed as a profession. One recommendation for hiring and on-boarding mental health interpreters is to support these interpreters in obtaining basic interpretation training with an additional mental health specialty, including continuing education to maintain an updated knowledge base. **Creating professional standards and training these mental health interpreters will help them become an integrated part of the mental health service system. This type of professionalization will build much needed infrastructure for mental health interpreters to be an integrated part of the mental health model.**

Cultural Responsive Outreach in Community

Given the diversity in AANHPI communities, the public mental health system must invest resources in the community to provide culturally and linguistically appropriate outreach efforts. To many community members, this can be the gateway to mental health services. Not only do materials and signage need to be culturally relevant and linguistically appropriate, they will also need to use community-friendly terms and format so that people are more likely to respond to these efforts. For outreach efforts to be non-stigmatizing, they can be integrated with cultural events or activities. While some of these efforts can be aimed at a more general or cross-cultural setting, it often pays off to have a targeted outreach to a specific cultural group to maximize its impact and relevance. There have been effective efforts made to promote mental health education within the context of traditional celebrations and cultural holidays. When designing these events, resources should be allocated for food and snacks, which are considered culturally congruent and a friendly gesture within the AANHPI communities.

Since many AANHPI community members and consumers are immigrants, understanding the immigrant experience is important. Many of them also come as refugees and/or asylee and have experienced tremendous amounts of trauma and torture. Hence, **it will be important to consider a trauma-informed approach and to seek understanding of these immigration experiences when working with the AANHPIs.**

A culturally responsive outreach must also include consideration for the age group and characteristics of a specific subgroup (e.g., gender expression and sexual orientation). When conducting outreach to youths and TAYs, utilization of social media and youth cultural activities (e.g., music, dance, art) should be considered. As for outreach to LGBTQ groups, a gender-neutral and affirming attitude will be of utmost importance, while maintaining sensitivity to traditional views of gender in each culture.

Holistic Services to Decrease Mental Health Stigma

One consideration of decreasing mental health/illness stigma is integrated care. It will be meaningful to consider embedding mental health service in holistic full-service environments whenever possible. Many people communicated the need for an integrated service that targets both physical health and mental health. They considered this a good way to deal with stigma associated with mental health issues. When mental health referrals come from primary care providers, people may be more likely to follow through as they are more accustomed to follow "the doctor's order." When physical and mental health care are co-located, people are less likely to feel burdened as others may not immediately associate it with mental health service. This will also help address the stigma of going to a mental health service agency. When designing a program to help address mental health issues, one may also consider integrating traditional healing and herbs as supplemental components to help people deal with stigma, as they are more familiar with and bought into this traditional healing approach. When indicated, programs should also consider integrating the spiritual component of healing, because spirituality is a prominent factor in the AANHPI experience.

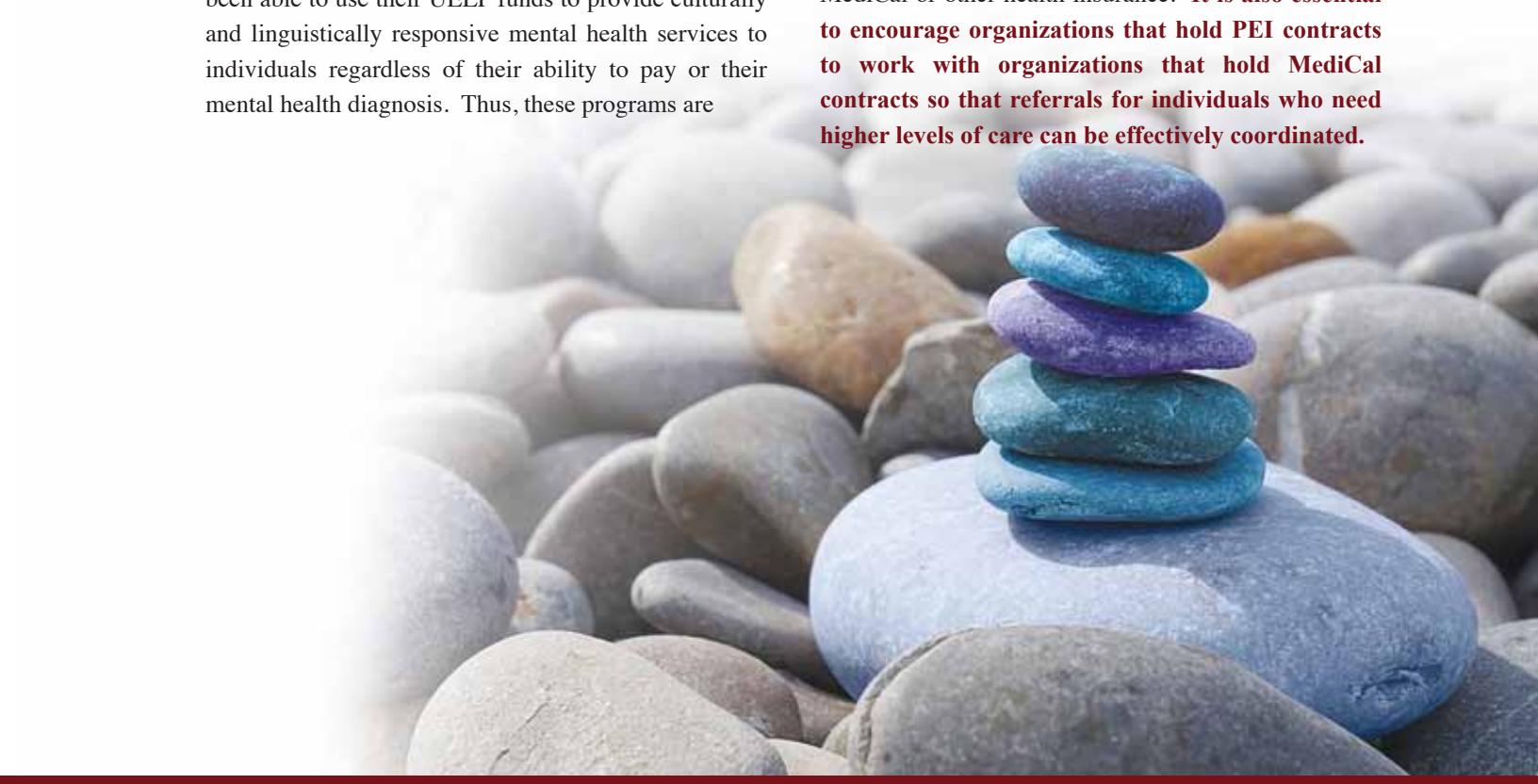
Collaborations Between Prevention and Early Intervention (PEI) Providers and Medi-Cal Treatment Providers

MHSA PEI Underserved English Language Population (UELP) has been the clearest and most dedicated strategy in ACBHCS's efforts to address the issues, barriers, and challenges discussed in this report. It is the most flexible funding stream in the current system in terms of redesign potential, and should be central to strategies for increasing the utilization of mental health services by AANHPIs in Alameda County.

UELP could serve a critical role in connecting community members to appropriate levels of care beyond prevention and early intervention. UELP programs have already successfully modeled strategies for engaging AANHPIs and reducing stigma by pulling from culture, expressive arts, traditional healing, and individual/group/community/collective empowerment. These programs were able to bring communities into the public mental health system in a safe and culturally aligned manner. These strategies should continue to be supported and valued for their effectiveness with AANHPI communities. Several UELP programs have been able to use their UELP funds to provide culturally and linguistically responsive mental health services to individuals regardless of their ability to pay or their mental health diagnosis. Thus, these programs are essential safeguards and mental health supports for those who are ineligible for Medi-Cal or other forms of health insurance.

It is important to continue investing in prevention and early intervention (PEI) models and providers. It is also important to continue investing in non-mainstream mental health models and providers that involves culturally relevant, innovative strategies that promote cultural wellness. **PEI programs may include these modalities: expressive arts, empowerment, traditional healing and cultural preservation; peer support groups that leverage community resources; interventions that integrate concrete basic needs and skills development; as well as inter-community work and community events.**

In other words, it will be very beneficial to focus on PEI as a key node in the system to improve mental health service utilization for AANHPIs. It is important to protect PEI funding as it is often the only resource for serving immigrant communities, including the undocumented and uninsured who do not qualify for MediCal or other health insurance. **It is also essential to encourage organizations that hold PEI contracts to work with organizations that hold MediCal contracts so that referrals for individuals who need higher levels of care can be effectively coordinated.**



IX. County Response – next steps

Innovation Grant Projects

The current AANHPI Mental Health Utilization study points to several areas of focus that could improve the service utilization of AANHPI communities. Alameda County is working on addressing some of these areas through its Innovation Grants Program funded by the Mental Health Service Act. ACBHCS is planning to issue a Request for Proposal (RFP) for pilot projects to implement innovative and culturally responsive strategies and programs that address barriers for accessing mental health services in AANHPI and refugee/aslyee communities.

Stakeholder Involvement

As the needs of the AANHPI communities are much greater than the current system can address, it is important to continue seeking input from stakeholders in the system. The crucial involvement of stakeholders in discussing, brainstorming, reviewing, and monitoring service plans and delivery can help to ensure that limited resources for the community are best utilized and to reduce wasteful or ineffective efforts. A committee of culturally responsive AANHPI stakeholders comprised of community experts, consumers, family members, and county staff should be consulted at various stages of the service planning and delivery. This group can provide the leadership and influence to help Alameda County work more collaboratively with the community to address potential issues that challenge the invisible, un-served, underserved, and inappropriately-served API communities.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