alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

WELLNESS • RECOVERY • RESILIENCE

2000 Embarcadero Cove, Suite 400
Oakland, California 94606
510-567-8100 / TTY 510-533-5018
Carol F. Burton, MSW, Interim Director

MHSA STAKEHOLDER GROUP (MHSA-SG)

Friday, February 25, 2022 (2:00-4:00pm)

GO TO MEETING TELECONFERENCE: https://global.gotomeeting.com/join/511501621
United States (Toll Free): 1-646-749-3129; Access Code: 511-501-621

MISSION	VALUE STATEMENT	FUNCTIONS
The MHSA Stakeholder Group advances the principles of the Mental Health Services Act and the use of effective practices to assure the transformation of the mental health system in Alameda County. The group reviews funded strategies and provides counsel on current and future funding priorities.	*We maintain a focus on the people served, while working together with openness and mutual respect.*	The MHSA Stakeholder Group: • *Reviews* the effectiveness of MHSA strategies • *Recommends* current and future funding priorities • *Consults* with ACBH and the community on promising approaches that have potential for transforming the mental health systems of care • *Communicates* with ACBH and relevant mental health constituencies.

1. Welcome and Introductions 2:00
   - Happy New Year!

2. MHSA Podcast for youth

3. FSP Presentation: STRIDES (Telecare Corp) 2:15

4. CPPP Update for FY22/23 2:45
   - "How to Read the MHSA Plan" webinar themes
   - NEW: RBA MHSA summary for Plan
   - INN Proposals & CPPP Form
   - CPPP Input Question Brainstorm

5. General Updates & Announcements 3:45
   - Leg Update: H.R. 5986
   - FASMI Protest 2/14/22
   - Calendar/Next meeting
   - County Selection Committee (CSC) opportunities

6. Wrap-Up 3:50

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7. Meeting Adjournment 4:00

Documents Attached:

- Meeting Calendar 2022
- Agenda
- PPT
- MHSA RBA Examples & Service Team Report
- INN Proposals
- STRIDES Program Overview & Admission Criteria

Alameda County Mental Health Services Act Stakeholder's Meeting
January 28, 2022 • 2:00 pm – 4:00 pm
TELECONFERENCE REMOTE MEETING

Meeting called to order by **Mariana Real (Facilitator)**

Present Representatives: Viveca Bradley (MH Advocate/MHAAC/AA Family Outreach), Margot Dashiell (Family Member/East Bay Supportive Housing Collaborative/African American Family Outreach Project/Alameda County Family Coalition), Annie Bailey (City of Fremont-Youth & family Services Division), Jeff Caiola (MH consumer advocate /Berkeley Depression Bipolar Support Alliance-DBSA), Liz Rebensdorf (Family Member/NAMI East Bay/MHSAAC), Mark Walker (Deputy Director, Swords to Plowshare), Sarah Marxer (PEERS/Family Member); Carissa Samuels (TAY/Ohlone College Mental Health Ambassador); Lee Davis (President, MHAB)
Guest Representatives: Ihande Weber

ITEM	*DISCUSSION*	*ACTION*
Welcome and Introductions (Mariana)	**Mariana** reviewed conference call etiquette tips, and led a brief check-in with the group utilizing the Community Agreements and MHSA-SG Design Team Alliance (DTA) model to identify the desired atmosphere for the meeting and strategies to ensure members thrive and deal with conflict. The group would like to focus on: • Respect for perspectives and where they are • Advocate for collaboration	
Presentation: Mental Health Peer Coach Program – City of Fremont	**Ihande Weber, LCSW** Manager presented an overview of the Mental Health Peer Coach Program in South County. *Please view the full PPT presentation from the 3/26/21 MHSA-SG meeting* The program is housed under City of Fremont's Aging and Family Services Division which provides services for seniors 55 years of age and older. The Sr Mobile Mental Health program target populations is 60 and over, typically experience challenges such as chronic health, mental illness, functional limitations, isolation, unhoused, and multicultural. The program addresses social network barriers, fragmentation of care through coordination, counseling, transportation and wellness support/education. The goal is self-empowerment, better health management, engagement, and wellness. • Recovery & resiliency Program provides the Step-Down Program, on-going support and monitoring, rehabilitation, groups, skill building. • Mobile Mental Health provides individual therapy, group therapy, case management, medication support, and crisis intervention. **Please review meeting PowerPoint for a comprehensive overview of the program.** Stakeholder Question & Answer	• **MHSA-SG** will review the PEI component of the three-year plan on the acmhsa.org website • **Ihande** will send GrandPad information to mariana.

ITEM	*DISCUSSION*	*ACTION*
	Viveca: What's the slice [proportion] of African American [served in your program]? • **Ihande:** About 27% so 9 clients. **Margot**: Do you do medication management? Do your reorder [prescriptions]? Does medication management work? • **Ihande:** We review medication support during enrollment. A clinician assesses and prescribes medication. The program monitors compliance. The psychiatrist/PA refills medications. **Liz**: Excited about the thing called GrandPad- never heard of it before. Its good not just for seniors but folks with mental illness who can use another option for communicating and are overwhelmed by the computer. Can you tell me more about it, what it offers that regular stuff wouldn't? • **Ihande:** Our administration put in a requisition from a community agency. **Liz** asked: When a person comes into the program, is part of the application the city of residence or how do you work that? • **Ihande:** Our program serves tri city area in our contract **Carissa** asked: I wondered how this works in terms of early intervention/prevention since you receive PEI • **Ihande:** Our LGBT program, criteria are those clients demonstrating some symptoms **Lee Davis:** I wonder with restructuring so there's no diagnosis, I know MHSA is intended to help people with serious mental illness, do you feel as if you're being culturally responsiveness…I trying to understand where the criterion is. • **Ihande:** Our clients do have issues, we have to evaluate and assess more. **Viveca:** I find the mobile mental health program fascinating and needed**.** Can you tell me how it came about? Is it part of your original program or separate MHSA grant? How did this come together? • **Ihande**: Prop 63/MHSA started it all. 15 years ago the City of Fremont lacked mental health services, a lot of senior services such as senior centers, case management, caregiver program, senior peer counselors, and youth and family services, family resource center) but mental health just started 15 years ago. Before I came, I worked in Santa Clara County mental health for years. **Liz:** You said there are no services in Fremont but it's part of Alameda County do you work with elder services in County mental health. • We work with South County support team in the city. The ACCESS program and others have eligibility criteria, they don't take clients not on Medi-cal. My program takes clients	

ITEM	*DISCUSSION*	*ACTION*
	both Medicare and Medical because when they reach a certain age like 65 they may switch to a different major HMO. **Jeff**: The Fremont Family resource Center- where do they fit in with your services? • **Ihande: T**hey are across the street from us. They have 24 different agencies. • **Annie comments** the center is a division of Human Services Department and a physical building. 24 agencies are relocated there providing a myriad of services. **Mariana** How do you plan to recruit for the LGBTQIA peer program What is your existing network, how will you identify participants? Have you tried PRIDE Coalition, MHAB Older Adult Committee? • **Ihande**: Different providers, hospitals, clinics, senior housing. We would appreciate additional linkages.	
FY22/23 Annual Plan Update: CPPP & Innovation Update	**Mariana** reviewed two Innovative proposals from the consultant Indigo Project. The department will move forward with soliciting feedback during 30-day public comment period. • Peer/Family member • Clinical **Mariana** will discuss 30-day comment outreach strategies with group members during the next meeting.	• **MHSA-SG** will review the PEI section on the Community Input page of the acmhsa.org website
MHSA-SG Administrative Updates/Membership and Announcements (Mariana)	**No new applications**	
Wrap-Up/Summary (Mariana)	Next MHSA-SG meeting will feature a presentation from CSS Service Team the next meeting **The group identified future meeting topics**: • *Swords to Plowshares White Paper* • *Peer Support Services – peer certification training* • *FSP program (STRIDES)* • *Supportive Housing* • *Legislative Review* • *Deaf & hard of Hearing Programs* • *Conservatorship* • Circulate 30-day public comment period information when provided in April	• **Mariana** requests membership biographies from new members • **Mariana** requests members to update their information on SurveyMonkey • **Mariana** will send an email to summarize today's meeting and required reading materials for the next MHSA-SG meeting

Next Stakeholder meeting: Friday, February 25, 2022 from 2-4 p.m. LOCATION: GoToMeeting

MHSA-SG MEETING

ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES, MHSA DIVISION

FACILITATOR/COORDINATOR:

MARIANA REAL MPH, MCHES


HELLO
MY NAME IS

MEETING OBJECTIVES

- Welcome & Introductions
- Presentation: STRIDES (CSS program)
- CPPP Update FY22/23
- General Updates/Announcements
- Wrap Up
- Adjournment

COMMUNITY AGREEMENTS/DTA

Atmosphere?
The feeling we want to create

Thrive?
What we need to do our best work

Deal with Conflict?
How we'd like to handle difficulties/conflicts

STRIDES

(**S**teps **T**oward **R**ecovery, **I**ndependence, **D**ignity, **E**mpowerment & **S**uccess)

Leslie Kaplan, LCSW
Administrator, Telecare

STRIDES: Creative, Collaborative, Partner-Centered Services

- **STRIDES is Considered the Oldest ACT Program in California (Assertive Community Treatment); Opened in 1994**
- **Census of 100 Partners; 2 Teams of 50 Each; 7.4:1 Ratio of Partners to Staff**
- **Recovery-oriented, Intensive Services Provided in the Community, *Wherever* our Partners are Located**
- **Team-based Approach**
- **Services 7 days a Week, Including Crisis Response Overnight**
- **Referral via ACCESS. Referral Criteria Include: Diagnosis of SMI, MediCal, 18 years or older, Alameda County Resident**
- **Evidence-based Skills, Including: MI, CBT, DBT, Seeking Safety, Life Skills**
- **Utilize a Whole Person Care Lens**
- **Strong Collaborative Relationships with Other ACBH Providers, Medical, Housing, SUD Services, etc.**
- **We Use Telecare's RCCS (Recovery-Centered Clinical System) and CoEG (Co-occurring Educational Group)**
- **Rated as High Fidelity on our Most Recent ACT Fidelity Review**
- **CARF Certified (Commission on Accreditation of Rehabilitation Facilities)**

How Much Did We Do?

In Fiscal Year 2020/2021:

- **We Provided 9,959 Hours of Service to 106 Unique Partners; Including 534 Hours Non-Billable**
- **We Served People Ages 22 – 79**
- **We Welcomed 7 New Partners**
- **We Initiated an Agreement with the Managers of an 11-bed Independent Living Home, in which All the Beds are Available for our FSP Partners**
- **We Provided Seeking Safety and Co-occurring Education Groups at Three Separate Locations**
- **We Offered a monthly Family Support Group via Zoom**
- **We engaged 25 partners in Vocational Services Using the IPS Model**
- **We Helped Train a New Generation of Community-based Behavioral Health Care Providers by Welcoming 7 UCSF Nurse Pracitioner Students; 2 Cal MSW Students and One OT Student for Internships**
- **We Got Creative During Covid!!!**

How Well Did We Do It?

In Fiscal Year 2020/2021

85% of Partners received a follow up visit within 30 days of hospital discharge

73% of Partners received a follow up visit within 5 days of discharge from a psychiatric hospital….

71% of Partners received *at least* 4 visits per month

72% of Partners experienced a decrease in jail days from the previous year

79% of Partners experienced a decrease in Psychiatric Emergency Room, Inpatient, &/or Crisis days over the previous year

96 of Partners were housed

Is Anyone Better Off?

Success Stories

MHSA ANNUAL UPDATE/CPPP

MHSA Three-Year Plan/Plan Update Cycle

July-September

- Gather previous fiscal year data from MHSA funded programs.

October-February

Listening Sessions for the Community Program Planning Process (CPPP).

January-March

- Develop drafts of MHSA Three -Year Plan/Plan Update.
- Review of MHSA drafts with MHSA SG and ACBH Leadership.
- ACBH Leadership approves the MHSA budget.

April

- Three-Year Plan/Plan Update is posted for 30 day Public comment period.

May

- Public Hearing at the Mental Health Advisory Board to close the 30-day Public Comment period.

June

- Presentation to the Board of Supervisors Health Committee.
- Full Board Approval.
- MHSA Three-Year Plan/Plan Update is sent to DHCS & MHSOAC.

“ How to Read the MHSA Plan” Webinar

What suggestions do you have to ?

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Community Input Questions

What suggestions do you have to improve the questions/ what needs improvement? + /Δ

- **What are the top or most pressing mental health issues right now in your community?**
- Are there **individuals, groups and/or cultural communities** who you believe are not being adequately served?
- What do you see as **barriers** for people to get help?

  What are your **ideas** on how to better serve our communities?
- **What MHSA-funded services are you aware of**, either as services you or someone you know has taken advantage of or as services you would feel comfortable recommending to others?
- **Other comments** people want to share?

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GENERAL UPDATES/ANNOUNCEMENTS

Legislation

2022 Emerging Issues: LPS/Conservatorship Reform, BH infrastructure and workforce

2 YR Bills (may be acted on 1/2022):
SB 57 (Wiener) Controlled Substances: overdose prevention program pilot

Bills of Interest:
AB 383 (salas): Behavioral Health: Older Adults
AB 552 (Quirk-Silva): Integrated School-Based Behavioral health partnership program
AB 686 (Arambula): CA Community-based behavioral health partnership program
SB 387 (portantino) : Pupil health: school employee and pupil training: youth and mental/BH
SB 773 (2nd house, 2 yr bill): Medi-Cal managed Behavioral Health Services
H.R. 5986: Men's Health Awareness and Improvement Act

MEETING WRAP-UP

- Future Presentation:
  - Swords to Plowshares White Paper
  - Peer Support Services – peer certification training
  - Supportive Housing
  - Legislative Review
  - Deaf & hard of Hearing Programs
  - Conservatorship
- Survey Monkey (update contact information) & Member Bio
- Submit agenda item requests on the website
- Celebrate your accomplishments!

THANK YOU

Next Meeting:
March 25, 2022
2:00 pm– 4:00 pm
(Virtual)

** Stipends: Follow-up with Mariana Real

Alameda STRIDES

Assertive Community Treatment

At Alameda STRIDES, we are here to support you in taking positive steps towards living successfully and independently within your community.

We believe that recovery is possible with the right plan in place. Our job is to do whatever it takes to support you on your recovery journey. Our multidisciplinary team includes a psychiatrist, nurses, masters-level clinical staff, case managers with experience in both drug and alcohol and mental health, peer support specialists, and vocational specialists who are all here to help you on your path.

Our program is based on the Assertive Community Treatment (ACT) model, where we connect you to the resources that can help you achieve your goals. We will work together with your family, friends, and community to help you take steps toward making recovery happen.

What to Expect

Your support services start with your hopes and dreams. STRIDES staff provide welcoming and respectful services that utilizes a partner-centered, individualized approach that emphasizes personal choice and empowerment. Our services emphasize choice-making skills and harm reduction techniques.

Our culture is based on recovery. We believe in respect and non-judgment, and we celebrate individual uniqueness. We care about the interpersonal relationships we develop so we can foster a supportive environment.

Our staff are passionate, resourceful, and motivated. They are your partners in recovery and will be throughout your journey.

Our goal is to be a place that helps you thrive. We want you to be the leader of your recovery journey, and to create the life you want for yourself.

> "The goal of recovery is not to become normal. The goal is to embrace the human vocation of becoming more deeply, more fully human."
>
> — PATRICIA DEEGAN, PHD, FOUNDER OF COMMONGROUND

CONTACT

280 17th Street
Oakland, CA 94612
510-238-5020 Main
510-261-3584 Fax

OFFICE HOURS

Monday - Friday: 8:30 a.m. to 5:00 p.m.
After hours and on-call service are available 24 hours a day, 7 days a week

Services at STRIDES

- Medication and symptom support
- Support with health care coordination
- Collaboration with social supports
- Individual rehabilitation
- Family connection
- Addressing internalized stigma
- Independent living skills training
- Assessment, treatment planning and safety planning
- Vocational and substance use services

Becoming a Member

Partners are referred through Alameda County Behavioral Health's ACCESS referral line. ACCESS will assess for appropriate level of care and review admission criteria.

Admission Criteria

- Must be a resident of Alameda County, ages 18 and older
- Have a diagnosis of serious mental illness
- Have Medi-Cal or be Medi-Cal eligible

Our Story

STRIDES is one of the oldest ACT programs in California and participated in early research demonstrating that people who participate in ACT programs have more successful outcomes.

STRIDES staff love to celebrate with our partners. We strive to empower them by having a Partner Advisory Council. We celebrate all the major holidays with partners including parties, luncheons and barbeque's. We especially love acknowledging and celebrating partner successes.

WE WANT TO HEAR FROM YOU!

Help shape and impact Alameda County's mental health system!

COMMUNITY PROGRAM PLANNING PROCESS & 30-DAY PUBLIC COMMENT NOTICE for the Alameda County Mental Health Services Act Annual Update FY22/23

HHREC MHSA PODCAST

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MENTAL HEALTH SERVICES ACT · PROPOSITION 63 · CALIFORNIA

HHREC HEALTH & HUMAN RESOURCE EDUCATION CENTER

MHSA is funded by a 1% tax on individual incomes over $1 million.

ALAMEDA COUNTY BEHAVIORAL HEALTH SERVICES INVITES YOU TO:

Contribute ideas about how to improve the County's mental health services between 4/1/22 – 4/30/22

Share information about the Mental Health Services Act.

Learn more about MHSA podcasts and events,
read the MHSA plans, and provide public comment at

acmhsa.org

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Alameda County Behavioral Health
MHSA Innovation Proposals: Forensic Focused

Dates: August 27, 2021 and September 3, 2021

Action Items

- The community is interested in understanding data on how many people in jail facilities have a serious mental illness. The Mental Health Advisory Board (MHAB) is working with the department to get this data, and it would likely be available in that forum.
- Community members would like opportunities to view and pilot the WRAP for Reentry curriculum before it is fully implemented.
- Questions about the forensic peer specialist specialization should be directed to Mary Hogden and the department.
- Tracy will share the community's priority of youth diversion with the department and bring back any information from the department about their plans to develop diversion and other interventions for at-risk and justice involved transition age youth.

Key Themes

Across Both Concepts

- Substance Use: For both concepts, ensure that substance use is highlighted and that all programs are equipped to adequately serve individuals with co-occurring disorders.
- Cultural Responsiveness: Cultural responsiveness goes beyond UELP. Ensure that description of concepts is explicit about the focus of serving BIPOC communities and how they are disproportionately affected by the criminal justice system.

Peer MHSA Innovation Concept: #1: Peer-led Continuum of Forensic Services

- Target Populations and Referral Pathways: Clarify how these programs fit in with larger continuum of services and specifically clarify the target population and referral paths for the Peer Continuum and the Alternatives to Confinement.
    - For example, clarifying which populations would be appropriate for a Peer Respite that is not a clinical program versus a Forensic Crisis Residential Treatment (CRT). Additionally, it is important to let people understand the role of Peer Respite as a short-term program to give a person a moment of pause to help them transition and to place services like a Peer Respite within the larger initiative. Perhaps clarify what alternatives are there for someone after 2-weeks in peer respite.
    - Be explicit in INN descriptions about how services connect people to other services, including economic relief.

Family Navigation and Support: Increase role of Family Navigation and Support. The community supports the idea of written materials, but family members need more support. For example, the attendees like the idea that families can be involved in coaching; participate in in-person support groups; and that people on warm lines will be trained on forensic issues.

- Both during incarceration and coming out, would like to have family support group options. Facilitators noted that while the INN concept was initially conceptualized as a phone-based consultation, they will add in-person support for families.
- Help family members to assist with reentry. For example, have family members be able to work with the Reentry coaches.
- Consider WRAP for family members. Family members participate in WRAP now, so make sure this is built into the new WRAP services. Additionally, the community members would like opportunities to view and pilot the WRAP for Reentry curriculum before it is fully implemented.

- Role of Peers: Set clear language in proposal about the role of Peers in the Continuum including:
  - Clarifying that WRAP will be done by peers.
  - Ensure Forensic Peers Specialists are used in all programs that use Peers. The Forensic Peer Specialist designation ensures peers have additional training and lived experience in the justice system. This designation is tied into the SAMSHA GAINS center and should be used in any Forensic program with peers.
  - Make sure education and training is a strong component of concept.

MHSA Innovation Concept #2: Alternatives to Confinement

- Collaboration of new INN programs with existing initiatives that may be led by Alameda County Behavioral Health or other departments: Make sure the community, law enforcement, and referring parties understand the different array of diversion options.
  - While there is general support for more diversion settings and agreement that one of the best ways to reduce people with mental illness in jail is to create an array of diversion options, it can be confusing to navigate the different services. It may be helpful to work in collaboration with other departments to vet the concept and consider where it is best to place an arrest diversion/treatment center in the county taking into consideration other diversion services and how cross agencies can eventually publicize the different options, create navigation support, etc.

The community members mentioned existing programs such as Alameda County District Attorney's C.A.R.E.S. diversion program with La Familia as well as the Roots Community Health Center**Proposal 1: Peer Led Continuum of Forensic Mental Health Services**

The *Peer Led Continuum of Forensic Mental Health Services* is a collection of four (4) projects, of which three are peer led and one is family focused. The project specifically seeks to support mental health consumers who are justice involved by helping them transition back into the community following an arrest or incarceration, identify and address the issues that led up to their arrest and/or incarceration, and connect with mental health and other services to support them in their recovery and reentry journey. This project also seeks to build the capacity of family members to advocate on behalf of their loved one with a serious mental illness who has become justice involved. As a result of these projects, we expect that individuals will experience fewer episodes of arrest and/or incarceration and will have increased participation in ongoing mental health and other services. The included services are:

- Reentry Coaches.
- WRAP for Reentry
- Forensic Peer Respite.
- Family Navigation and Support.

Proposal 2: Alternatives to Incarceration Project

The *Alternatives to Incarceration* project is a collection of three co-located services that are intended to prevent incarceration and divert individuals from the criminal justice system into the mental health services. This project specifically seeks to divert individuals from incarceration in three primary ways, 1) when a mental health consumer who is forensically involved begins to exhibit early warning signs of a crisis with behaviors that may lead to police contact, 2) at the moment of police contact that may result in arrest, and 3) when the person has fallen out of compliance with their probation or parole and is subject to re-arrest. This collection of services seeks to provide services that prevent individuals with mental health and criminal justice involvement from being booked into the jail. Services include:

- Forensic Crisis Residential Treatment (CRT)
- Arrest Diversion/Triage Center

- Reducing Probation/Parole Violations (RP/PV)
  -

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Mental Health Services Act Fiscal Year 2020-2021 Year in Review

The **Mental Health Services Act (MHSA)**, Proposition 63, funds mental health services in Alameda County and across the state. The funds are divided among five components, two of which serve clients through multiple programs. During Fiscal Year 20-21, the *Community Services and Supports* and *Prevention and Early Intervention* components funded over 100 programs.

Community Services and Supports (CSS) use funds for direct services to adults with severe mental illness (SMI) and children with severe emotional disturbance (SED). CSS funds two areas: **Full Service Partnerships (FSP)**, which provide voluntary wrap around services to consumers or partners diagnosed with an SED or SMI and **Outreach and Engagement/System Development Programs (OESD)**, which cover multiple treatment modalities and services to those with SED or SMI.

Prevention and Early Intervention (PEI) services embrace an approach that engages individuals before the development of mental illness and intervene early to reduce symptoms. All **PEI** programs use outreach to connect with communities, provide access and linkage to necessary care, reduce stigma and discrimination associated with mental health, and promote wellness. A subset of PEI programs are the **Unserved/Underserved Ethnic and Language Populations (UELP)** programs, which focus on the Afghan/South Asian, African, Asian/Pacific Islander, Native American, and Latino communities.

How Much Did We Do?

141,815
people[+] were served by **112 MHSA** programs

98.7 million
MHSA dollars* budgeted for the **CSS** and **PEI** Components

42,756 people served by **74 CSS**
3,333 people served by **16 FSP**
39,423 people served by **58 OESD**

$84.6 million budgeted for **CSS**
$42.4 million budgeted for **FSPs**
$42.2 million budgeted for **OESD**

99,059 people served by **38 PEI**
60,826 people served by **13 UELP**
38,233 people served by **25 other PEI**

$14.0 million budgeted for **PEI**
$4.7 million budgeted for **UELP**
$9.3 million budgeted for **other PEI**

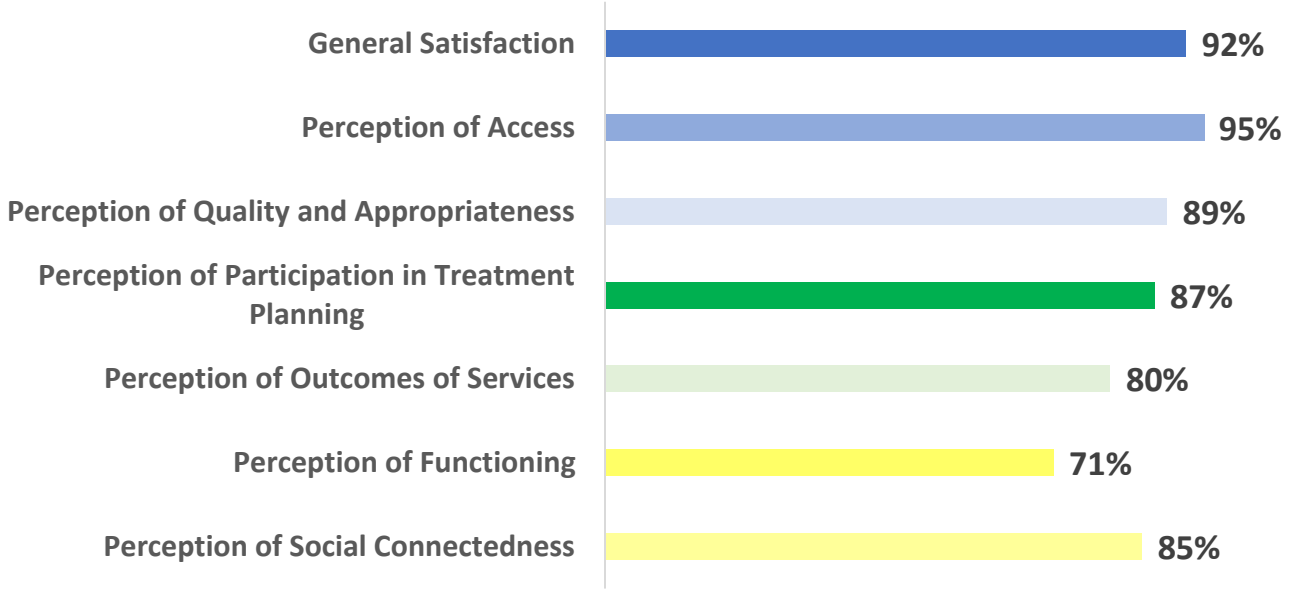
*All costs exclude administration costs, but do include a level of staff, training, and capacity building money in addition to all client focused costs.
[+]All counts contain duplicates

How Well Did We Do?

Every year clients that are served throughout the ACBH treatment system of care complete the Mental Health Statistics Improvement Program (MHSIP) satisfaction survey; this includes both **FSPs** and **OESD** programs. Below are selected results.

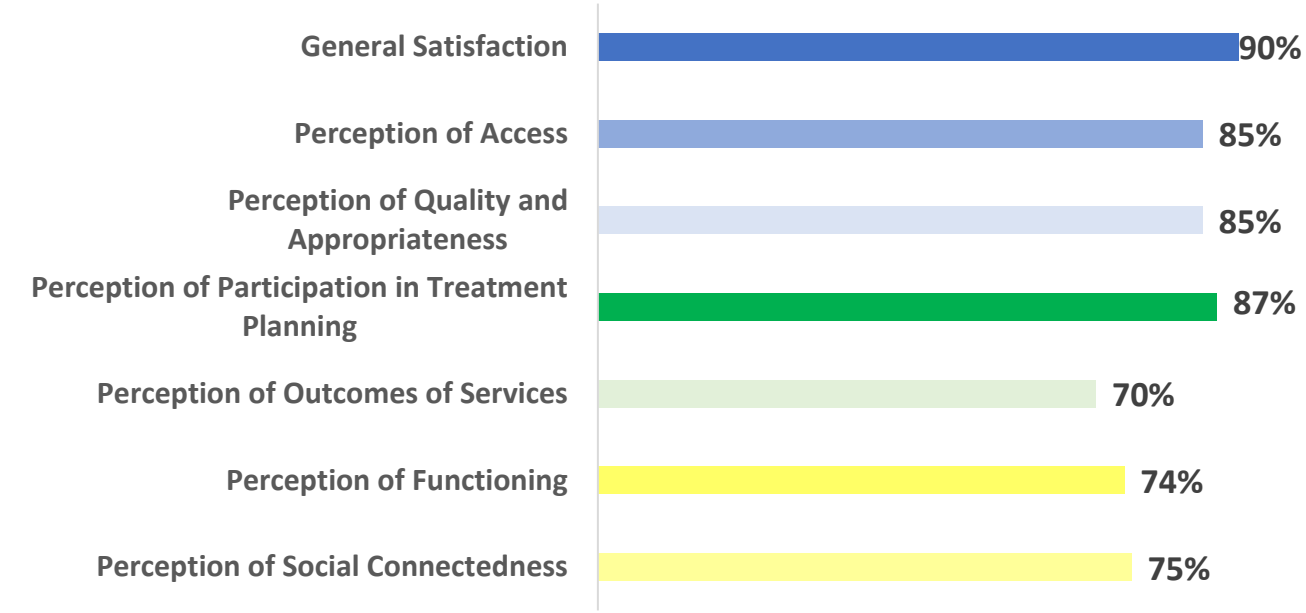
Spring 2020 Consumer Perception Survey Results Older Adults Ages 60+

Percentage of respondents who answered "Strongly Agree" or "Agree" to the survey questions comprising each domain *(n=31)*



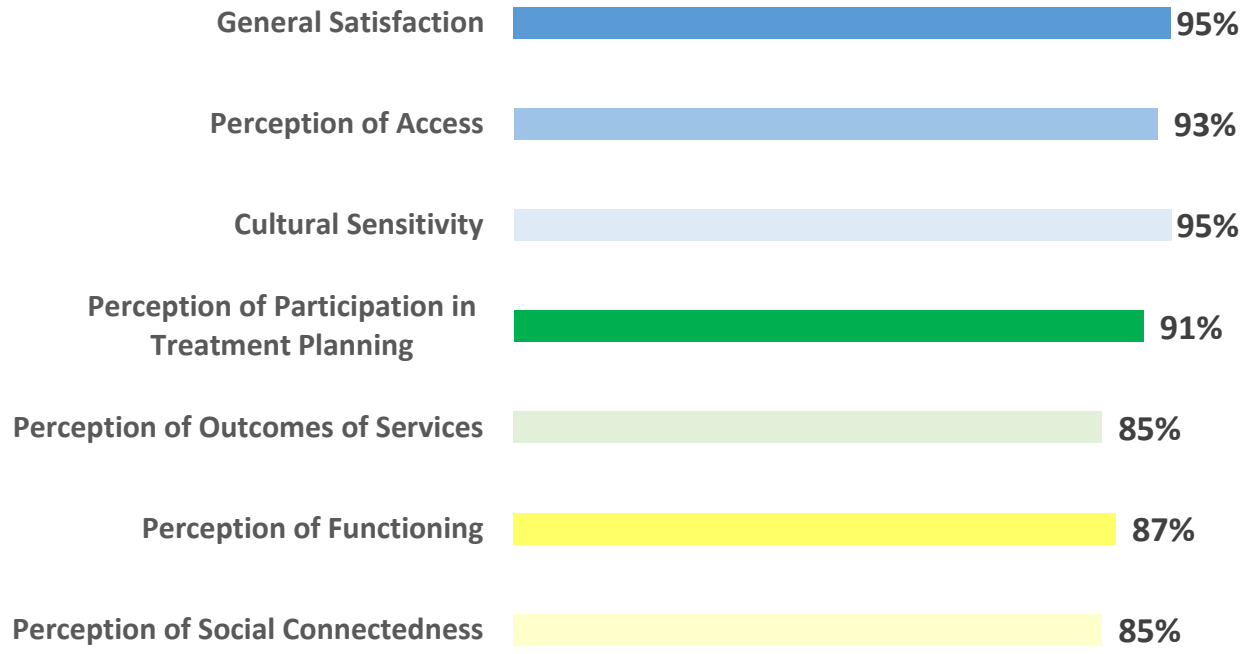
Spring 2020 Consumer Perception Survey Results Adults Ages 18-59

Percentage of respondents who answered "Strongly Agree" or "Agree" to the survey questions comprising each domain *(n=349)*



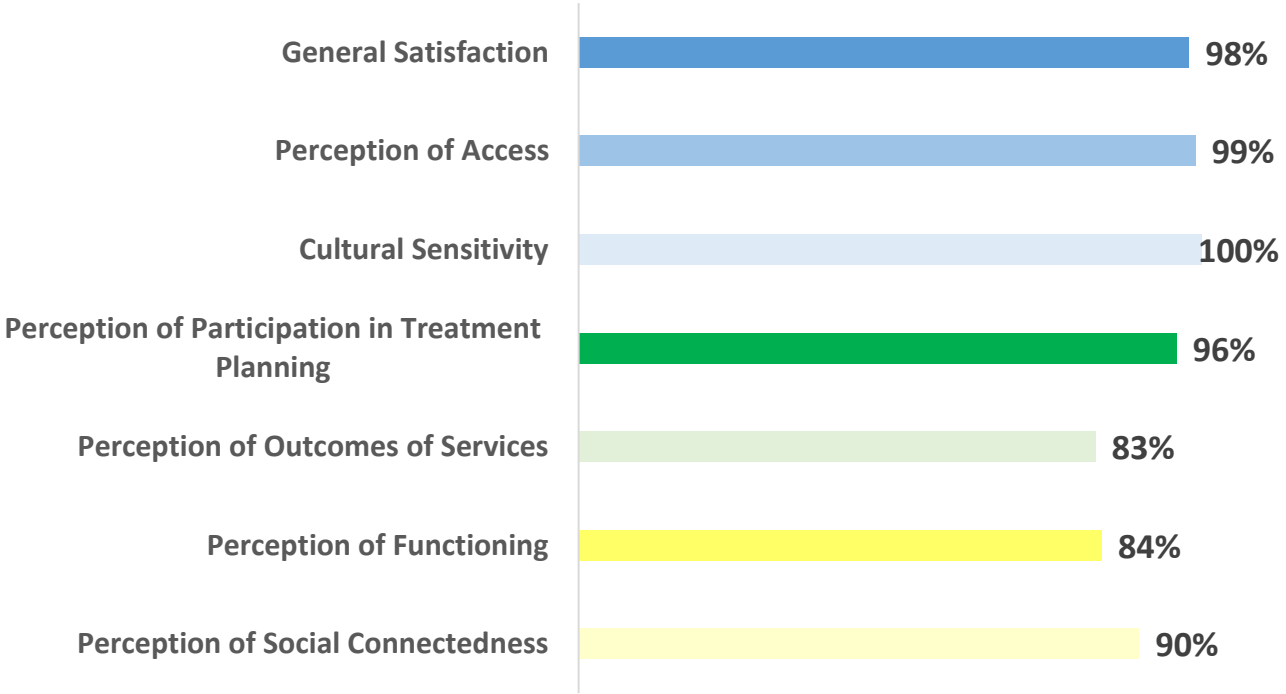
Spring 2020 Consumer Perception Survey Results Youth Ages 13-17

Percentage of respondents who answered "Strongly Agree" or "Agree" to the survey questions comprising each domain *(n=138)*



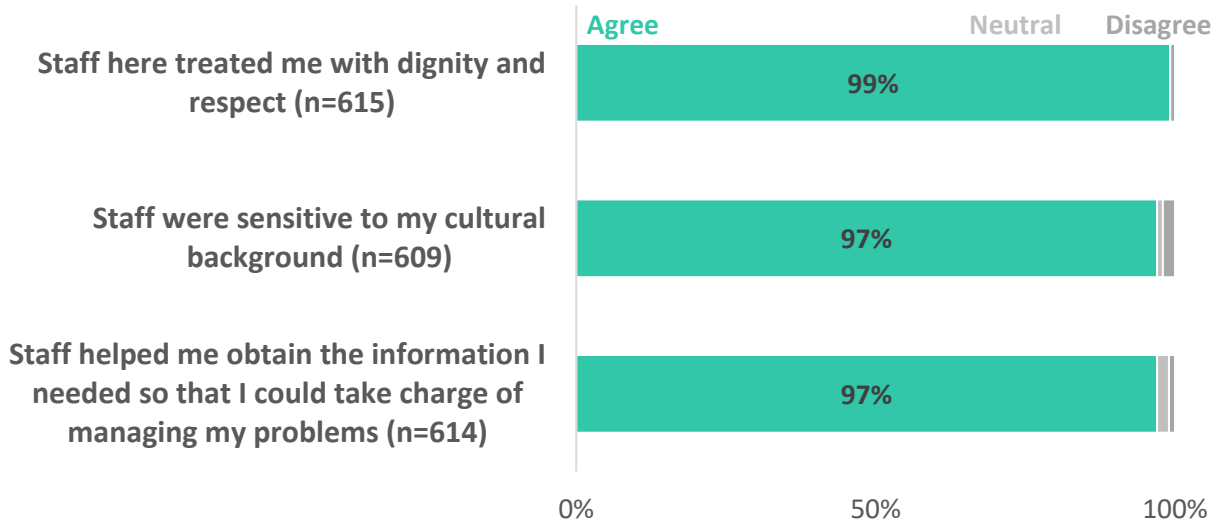
Spring 2020 Consumer Perception Survey Results Family/Caregivers of Youth Under 18

Percentage of respondents who answered "Strongly Agree" or "Agree" to the survey questions comprising each domain *(n=277)*

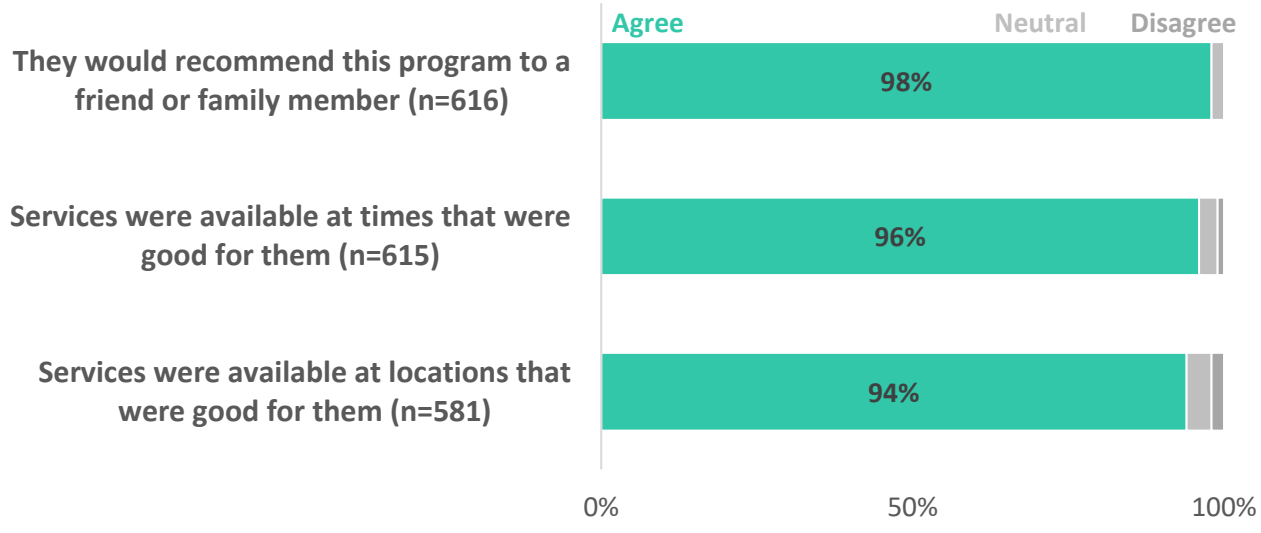


The subset of **PEI** programs, called **UELPs,** also complete a client satisfaction survey every year. The UELPs ask their program participants to fill out the survey during November to January during the fiscal year[1]. Overall, **UELP** clients are very happy with the services that they received.

UELP Clients were Satisfied with Services



UELP Clients think that Services were Convenient



[1] In future years this survey will be requested of all PEI programs.

Is Anyone Better Off? Selected Program Outcomes

FSP Client Quotes

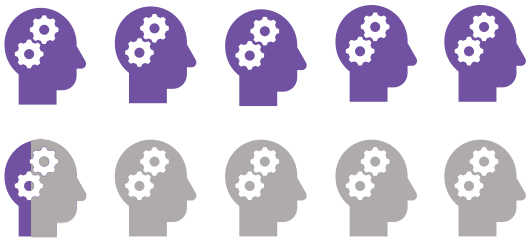
"They help me make it to appointments, they helped me get a phone, they helped me get the right medication so it's really nice of them."
"I got my own spot. They come through. They be helping. I wouldn't be here if not for [them]."

8 in 10

Adult FSP episodes had a decrease in both hospital and subacute admissions during the one year after enrollment.

53%

In Home Outreach Team clients were connected to outpatient mental health services within 90 days after discharge.



UELP Client Quote

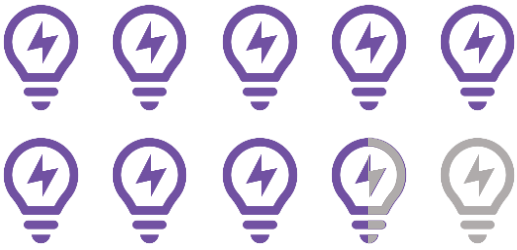
"I would have been in a stage where I'm just like depressed, feeling lonely, doing things for others while not even have the time for myself. Which is totally wrong. It taught us a lot of self-love."

84%

UELP clients that completed the Satisfaction Survey reported that they were better able to deal with crises after receiving services.

86%

REACH Ashland's youth survey participants reported that the Youth Center's PEI services taught them better ways to deal with stress or anxiety.



alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

WELLNESS • RECOVERY • RESILIENCE

Mental Health Services Act's Service Teams Report for Fiscal Year 2020-2021

Introduction

Program Background

Alameda County Behavioral Health's (ACBH) Service Teams serve adults and older adults (1 program) diagnosed with severe mental illness. While they are all strengths-based and recovery oriented, the staffing and program activities vary. However, all teams provide intensive case management services that work with clients:

> *"… to get them connected to resources in the community and to help them build their own internal reservoir so that they're able to live more independently and utilize crisis services less and live a more fulfilled and stable life." – Bonita House*

Service Team Program, Population Served, and Agency Type

Program	Population Served	Agency Type
Asian Health Services	Adults in North County who speak Asian languages	Community-Based Organization (CBO)
BACS	Adults	
Bonita House	Adults	
Felton Institute	Older Adults	
La Familia	Adults in North County who speak Spanish	
La Clinica, Casa del Sol	Adults in South County who speak Spanish	
Telecare Visions	Adults	
West Oakland Health Council	Adults	
Eden Community Supports Center	Adults	Alameda County
Oakland Community Supports Center	Adults	
Tri City Community Supports Center	Adults	
Valley Community Supports Center	Adults	

Report Rationale and Methods

Prior to Fiscal Year 2021-2022, most of the Service Teams were funded through Medi-Cal/Medicare billing and State of California realignment funds, which were impacted by the COVID-19 Pandemic. In order to continue to provide these important services the Services Teams will now be funded under the Mental Health Services Act (MHSA), which will replace the realignment part of their funding. MHSA funds mental health services in California through a one percent tax on personal annual incomes that exceed one million dollars. It is designed to expand and transform California's mental health systems to

better serve individuals with and at risk of serious mental health issues and their families. Locally, ACBH's MHSA Division is the agency that administers the MHSA funding.

One of the statutes of MHSA requires non-supplantation meaning that Service Teams will need to be transformed to be funded by MHSA. To explore possible transformation options the MHSA Division's Management Analyst performed hour-long interviews in June of 2021 with the Service Team's Program Managers.

Program Description

Program Activities

Programs provide a variety of activities to clients. Below are the services that the Service Teams provide to their clients, this is not an exhaustive list and additional activities are described in more detail below.

Program Name	Outpatient Services	In-Language Services (non-English)	Integrated Primary Care (PATH)	Substance Use Disorder Treatment (Options)	Supported Employment (IPS)	Substitute Payee Program
Community Based Programs						
Asian Health Services						
BACS (ICM)						
Bonita House						
Felton Institute						
La Clinica, Casa del Sol						
La Familia						
Telecare Visions						
West Oakland Health Council						
County Run Programs						
Eden Community Support Center						
Oakland Community Support Center						
Tri-City Community Support Center						
Valley Community Support Center						

Outpatient Services

The main category of services that the Service Teams provide fall under outpatient services, which include mental health services, case management/brokerage, crisis intervention, and medication support.

Aside from the above services, Asian Health Services, La Familia, La Clinica, Oakland, Telecare, West Oakland Health Council, and BACS programs described the support groups that they provide. The support groups range from clinical and SUD to health focused and one program even created an anger management class.

"We do have a WRAP group that is offered twice a week for family and clients and family members of clients. It's a supportive group run by La Familia." – La Familia

Physical resources are provided by many programs, which come from their board of directors, incentive programs, or in some cases donated from the community around them.

1. Funding for incentives – La Familia, Tri-City, Valley, La Clinica, and Eden

"There's a program that if we have savings on paying for people's medications it gets passed on to the clinics so we might get a couple thousand dollars a year. It's not a lot of money and we can buy gift cards with that a certain number of gift cards and then we have them for the year. So that if somebody one of the clients doesn't or didn't get a check or doesn't have food we can give them a Safeway gift card." – Tri-City and Valley

2. Hygiene kits – Asian Health Services and Oakland

"We are big on reaching out to get people to donate items to our clinic. We have hygiene kits that we give to our homeless population." – Oakland

3. Transportation around community – All but one agency, BACS, mentioned that they have vehicles for case managers to use or their agency provides some transportation. BACS case managers still transport client, but use their own cars and also provide bus and BART tickets to clients.

"We do maintain two vehicles that we use for transportation as needed. It's not always that we can help every patient with transportation because we only have two vehicles. But when we can it is useful to have those." – La Clinica

4. Social Activities, which included clients coming into the office to hang out (pre-pandemic) or organized events, were mentioned by La Clinica, Oakland, Tri-City, Valley, Eden, Bonita House, and La Clinica.

"Yeah, our peers maintain a community garden I think that's a source of peer socialization and agency building it's really lovely that they have it." – La Clinica

Although only mentioned by a subset of programs the **system-wide** resources that case managers would help clients connect with include:

1. Housing help – Asian Health Services and BACS

"We also have that HFSN, which is the Housing Fast Network, that's the Henry Robinson and the Holland hotels. Those are just basically what it sounds like they take people from just

straight up the street with the purpose of having them be able to come in or sleep inside save some money and then we'll work with them to get more stable housing." – BACS

2. Wellness Centers – Bonita House, Eden, BACS

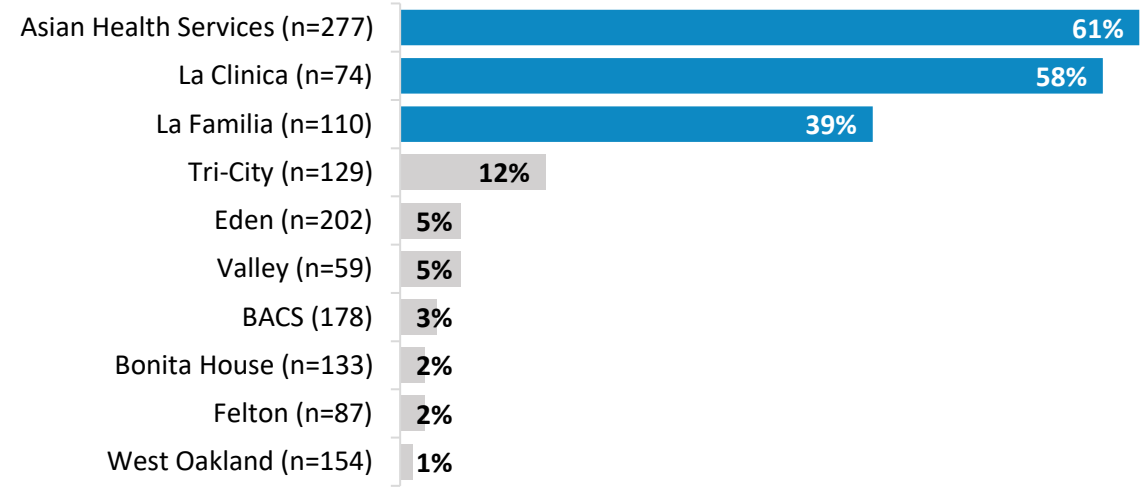
"We also just reopened the Wellness Center, which is fantastic. It was closed for over a year and before we closed we would literally have I don't know 30 people a day in there. We would serve food and people could come in first thing in the morning that have been outside all night and then you have breakfast and coffee there's someplace where you can be. It's one of the only places in Oakland, Townhouse our wellness center, where you can walk in without a referral and you're welcome there. Clients can get their mail sent there, we have a computer lab, we have groups. We just reopened and they have a full groups schedule put together." – BACS

In-language Services

There are three Service Teams that provide services in languages other than English. During Fiscal Year 20-21, La Clinica and La Familia served Spanish speaking clients and Asian Health Services served people in Cantonese, Cambodian, Vietnamese, Mandarin, Korean, Tagalog, Mien, Lao, Japanese, and a Chinese Dialect.

"I think some of the strengths is that we cover quite a few languages with the staffing arrangement. By having a psychiatrist that speaks the language, by having clinical staff counselors that speak the language, and also trainees and interns that we recruit. And of course, our clinical managers as well. That helps quite a bit with serving the diverse cultures and communities of the AAPI community." – Asian Health Services

Asian Health Services, La Clinica, and La Familia served the most non-English speakers during Fiscal Year 20-21



Note: Telecare served only English speakers during FY 20-21. Extracted from ACBH's Yellowfin Platform.

Primary Care and Health Focused Resources

Three county-run programs, Eden, Oakland, and Tri-City, contract with Federally Qualified Health Centers (FQHCs) to provide primary care integrated into the mental health services through the Promoting Access to Health (PATH) program. These services are needed because people with serious mental illness die on average 24 years earlier than the general population, primarily

due to chronic diseases like diabetes and cardiovascular disease[1]. While Asian Health Services, West Oakland Health Council, and La Clinica Casa del Sol do not have integrate primary care they are co-located with FQHCs. Asian Health Services also has dental providers that they can refer their clients to.

"Departmentally we have access to traditional healing and culturally acceptable component and care program that a lot of other service teams may not have. So, I think that's useful to us and our patients." – La Clinica, del Sol

"When her patients require an injection, they are sent on the unit to get one done by a nurse for another medical provider." – West Oakland Health Council

Substance Use Disorder Treatment

In addition to the PATH program the same three county-run clinics, Eden, Oakland, and Tri-City, also have substance use disorder (SUD) services integrated into the Service Teams. The SUD program called Options provides:

"…a group once a week and then they do a lot of community outreach for people who have substance abuse issues to try to engage them to try to address their substance use and especially as it interferes with their mental health treatment." – Tri-City

Other programs also have access to or provide in-house SUD treatment. Asian Health Services and La Clinica have internal rehab support and the program manager from Bonita House spoke about the dual diagnosis residential treatment programs that are meant to provide services to those that have a mental illness and a substance use problem. While these programs are available across the county they are limited so most of the SMI clients receive services from programs that are not meant to address both their SMI and their SUD.

Individual Placement and Support (IPS) or Supported Employment

The approach of IPS workers is to partner with clients and engage them around their unique interests and needs in:

- finding a job
- identifying employers
- applying for jobs
- and assisting with retention.

The IPS worker is embedded into the team and continues to collaborate with the client's clinical team and significant others to aid in their success. After a client is working, providers continue to support the individual until the job is secure and they are satisfied with the job match. If they want a different job or lose the one secured, IPS and clients keep looking for jobs to help find a better fit. There is a "zero exclusion" approach to recruiting clients for services, which means that if they are motivated to work and have expressed interest, they will be engaged despite any presenting barrier.

"What happens is the vocational programs that come on-site and join our service team in meetings and get to know some of the client's background and also meet with the clients to look for jobs that interest them or a suitable for them. We've been really successful with a vocational rehab specialist and team at the county to get jobs four our clients."
– Asian Health Services

[1] Manderscheid, R. (2006). Preventing Chronic Disease, 2, 1–14.

Substitute Payee

The ACBH Substitute Payee is a program that the Service Teams provide to accomplish the following goals:

i. Promote fiscal/benefits stability among clients.
ii. Support clients in maintaining basic needs including but not limited to housing, food, utilities, and clothing.
iii. Coach clients to achieve financial independence.

Oftentimes the case managers are the ones in the role of managing a client's money.

> *"Yet we have to do the SSI paperwork and tracking for so many different things. Any budget changes, any special money, any moves, any hospitals, any jails. They all require these forms that we have to do and can't bill for it's not a mental health service." – Telecare*

Staffing Patterns and Strengths

The staff makeup and configuration vary by team, but Program Managers mostly agree on the strengths of their staffing pattern.

Program Manager Role

Most of the teams have one Program Manager that does the following:

A. Supervise clinical staff (ensuring clinical services, practices) both licensed and unlicensed and administrative work.
B. Step in when understaffed and need a team lead or teams need help.

Two of the teams, La Familia and Felton, have two program managers. When interviewed, Felton had two interim licensed managers that were splitting the role, but the mode is similar to the description above. One of La Familia's program managers supervises the clinical aspects of the program and the other oversees the administrative and operations of the program and is unlicensed.

Team Staffing and Roles

The staffing patterns that focus on the case management activities vary by programs, however, all but one program falls into the two general categories below:

1. Primarily staffed by Master's level clinicians that do intakes, case management, and all assessments. Tri-City, Valley, Telecare, West Oakland Health Council, and Eden practice this pattern.
2. Licensed and unlicensed staff are clinical case managers that work together to provide case management services and day-to-day needs, with staff therapists or licensed clinicians that mostly focus on assessments and more intensive therapy. La Clinica, Felton, La Familia, BACS, Bonita House, and Asian Health Services practice this pattern.

> *"The program has two clinical case managers, those individuals focus on annual assessments with clients, they do some limited one-on-one therapy, they also hold a caseload of clients that are a little bit more acute. They're currently 2 case managers on the team if we're fully staffed there would be four and a case manager carries a caseload of about 30 individuals and they are providing mental health rehabilitation skills and case management to and with clients." – Bonita House*

Finally, the Oakland Community Supports Center has a unique staffing pattern with two teams that have a flexible engagement team embedded in each.

> *"Our engagement team is just that they have a smaller caseload and they get all of our new referrals. The thought and hope is that when we get new referrals they're able to meet with them more frequently and go out in the community and try to find them especially if they're currently not housed. We work with them on trying to get everything set up their initial assessment and treatment plan and their necessary referrals. After that is done then they are transferred to somebody on the regular team… if you [a team member] get an alert that they are at John George they'll [the engagement team] go immediately to John George to try to meet with them. They have a smaller caseload but they still do have their own caseload as well. Some consumers they'll work with them for 6 months, for some it'll be 3, for some it will be a year." – Oakland CSC*

Other Staffing Resources

Aside from licensed and unlicensed staff that focus on case management, there are other staffing resources that the programs have access to.

Administrative/Clerical Position were provided at Tri-City, Valley, Eden, and Felton. For Tri-City, Valley, and Felton they provide clerical support to help process paperwork for billing or answer phones. For Tri-City, Valley, and Eden Alameda County provides a staff person to help improve the quality of clinical documentation.

> *"I was going to say one of the things that the county does provide we just recently got a QA [quality assurance] person who is just working with the county teams… She comes to team meetings and I'll ask her sometimes to review charts… Staff's been very responsive to that that's felt very positive to them because they are doing so much paperwork that they would rather do it right and be done with it you know. And a lot of this stuff is sometimes hard to interpret so I think they feel better about their paperwork." – Tri-City and Valley*

Internship Programs are important to both cultivate and expand the workforce. During the listening sessions conducted by the MHSA Division internship programs were mentioned by participants as an important way to build the workforce. Below are the agencies that mentioned having interns during the school year.

Agency	Description
Asian Health Services	Psychology, social work, marriage and family therapists, and licensed professional clinical counselors
BACS	Master's degree practicum students perform the initial intake assessments and treatment planning
La Clinica Casa del Sol	Master's degree practicum students
Oakland Community Supports Center	UCSF Nursing and masters of social work interns
Tri-City and Valley	Social work and nurse practitioner students

> *"One thing that I will say is a change that has just been made that is really helpful that our Clinical Director started is a practicum program where we can have a new client come in and they will do the assessment and then treatment planning, which takes some of the weight off the clinicians." - BACS*

Staffing Strengths

Program Managers were asked about the strengths of the way that they staff their teams and overwhelmingly team collaboration was seen as a strength, regardless of the staffing patterns. Telecare, La Familia, Tri-City, Valley, La Clinica, Oakland, West Oakland, Eden, Felton, and Bonita House all mentioned team collaboration as a strength. The definition of collaboration varied from using a multi-disciplinary perspective or the case managers working together when short staffed.

> *"When a client starts with us they get three people, they get a med provider that's clinically appropriate, they get a peer specialist if that's appropriate, and they definitely get a clinician. I think one of the strengths of that kind of a staffing model is that a client, apart from just getting a lot of support, there's also a lot of different ways to approach the care…So, being able to share in that work can sometimes be helpful. And kind of tagging off of each other. I think also our clients benefit from having multiple people to support different goals for them. I think that's one of the strengths is just the collaborative approach to it. Like, "Hey, person X is kind of pissed off at me this week because I couldn't do Y so can you tag in this week to support." Really that kind of collective approach to the care is really one of the strengths" – Felton*

Another theme was community knowledge, defined as knowing what services and supports are being offered in the community and/or having linguistic capability. Notably, Asian Health Services, West Oakland Health Council, La Familia, La Clinica, which are the teams that serve 85% or more people of color and the three service teams that serve a lot of non-English speakers (range 39%-61%) mentioned this theme.

> *"I guess I'll start off with the paraprofessionals, although they do not have their credentials or the academic backgrounds they do provide a rich amount of experience and diversity to serve our population. Because they come from the communities that we serve they have a better understanding at times and the connection with the community members and such to be able to provide care, in language, to our population. I think in that respect the paraprofessionals are very valuable to us." – Asian Health Services*

The licensed clinical case managers were also seen as a strength because they are able to do clinical documentation and to provide some therapy to clients that need it. Asian Health Services, Telecare, Tri-City, Valley, La Clinica, West Oakland, and Bonita House, mentioned this as a strength. La Familia said that having a licensed Program Manager would take some of the burden off of the staff therapists, which focus on assessments and therapy, but do not have a caseload.

> *"I think the strengths are that there is always a clinical eye to whatever need is being addressed by our particular clients and patients. The same is not afforded when a case manager is sort of directing the services or the service provision at that given time. I think it's useful that a clinical person is both directing and connecting needs, they're also observing how they are participating in the world and has a better sense of how they can help them meet their treatment objectives and also observing and identifying different barriers." – La Clinica*

Client Success and Measuring if Anyone is "Better Off"

Success Definition

While ACBH collects and provides a lot of data for the Services Team, when the Program Managers were asked what success looked like for their clients and there was not one simple easy thing for providers. They did not have a unifying single definition for what success looks like. Most providers said that success is dependent on where the client starts and is dependent upon their goals.

"I think that depends on it's, sort of subjective in my opinion, I think it depends on the client and how they might define success and see what success is…A life worth living is one way to think of it." – Felton

While there was not a unified definition for success there are some commonalities among what the Program Managers said a successful client looked like. They spoke about clients having relationships with others, feeling like they can accomplish tasks, and making decisions about the direction of their life.

"I agree it's nice when they start to desire things like I want my DMV license, or I want to move out and not live with my parents. It feels like sometimes some of them are stuck in a younger developmental stage and they need a lot of support. Some of them they had that support they have that awareness and that desire to have that little bit of adult independence which is good we want them to be able to get there but it takes a lot of work to get them there." – La Familia

"But for some consumers who maybe have more severe issues or who have been institutionalized where they maybe spent many years at Napa or Gladman for them maybe success would be okay you're able to take your medications half the time or you're able to go independently to a doctor's appointment or even your able to ride the bus. I know there is I can't think of any case manager that we have that hasn't had at least one client that we actually had to teach how to ride the bus."– Oakland

Because there is not a definition of success for clients of the Service Teams, there seems to be difficulty in graduating clients from the program to some sort of lower level of care.

"I think one of the things that I still haven't necessarily gotten my head wrapped around is when somebody has achieved a level of success what does graduation look like and at what point do we talk about graduation? There are and not insignificant number of individuals on the caseload that have been clients of Bonita house for 20 years." – Bonita House

Other Data the Agencies Collect

In order to explore other ways that the Services Teams might measure success the Program Managers shared what other data their agencies collect. Some of the agencies review their demographics, the diagnoses of clients, and client satisfaction surveys in order to do program planning.

"We also look at basic demographic information, where our clients are coming from, where they're located, what zip codes, what ethnicities, what languages they speak. So, a lot of those demographic information we check routinely to see where things are going in our clinic. Then of course the clinics, the type of diagnoses we're seeing on the mental health side, what type of services they are coming in for. Is it more medication services? Is it more rehab services? Along those lines and the folk's gender and stuff like that." – Asian Health Services

"I think also we're looking at demographic data because we're curious about who were serving and who's successfully retaining in the program and not." - Felton

Although, a few Program Mangers said that their agency either does not collect more data (West Oakland Health Council) or are not focused on data because they are focusing more on the day-to-day management (Eden and BACS).

"I don't use it extensively because my focus is more on the work that we're providing to the clients so I get my mandates in terms of things that we need to be doing differently and tailor it

in that regards. Data doesn't mean a whole lot to me sadly because I'm really focused on the day to day with staffing." – Eden

Changes to the Program due to the COVID-19 Pandemic

Alameda County's first confirmed case of COVID-19 was reported on February 28, 2020, and the Bay Area's first shelter in place order went into effect on March 17, 2020. As of January 21, 2022, Alameda County has a cumulative 203,927 confirmed cases and 1,575 deaths. There are 81% full vaccinated residents in the county.

In-person Groups and Transportation

Many activities were affected by the Pandemic, including in-person groups, which stopped. Programs had varying success with moving them to online and/or teleconference. Asian Health services had low attendance in their virtual group, La Familia had good attendance at a teleconference, Oakland had phone groups but they were not as successful as in-person group. La Clinica, Telecare, West Oakland, and BACS did not replace their in-person group and Eden tried but was unable to implement it successfully. Clients also stopped hanging out at the office at Tri-City, Valley, and Eden.

Additionally, transportation changed because case managers could no longer provide it to clients, Telecare, Tri-City, Valley, and Eden mentioned this change.

"Absolutely things changed we used to have a program where people came into the office once or twice a week to attend groups and have lunch and that's something that went by the wayside in terms of people coming that clinic and sitting and waiting. They now have to utilize the back door because we didn't really want to have individuals you know in close proximity in the waiting room. Just not feeling like they had a home in some respects." – Eden

System-level Changes due to the Pandemic

The two biggest changes that occurred to the system was that clinicians could not work from home and community-based programs were hard to access.

"Everything was over Zoom even like the morning team meetings. Getting people to primary care was you know 20 times harder. If they were doing primary care over the phones. It's like, "Who's phone?" Are they calling the clients phone or they calling my phone?" – Telecare

Telehealth Implementation

Due to the initial shelter in place Service Teams and other specialty mental health providers in Alameda County implemented telehealth procedures for psychiatry and case management. Most provided telehealth during the initial shelter in place and then Oakland and BACS, quickly transitioned back to primarily field-based case management work. Although, all programs are now seeing clients in person either out in the field or in their office.

"I think during the first couple weeks we were so confused we started with making phone calls, but we quickly realized that does not work for our clients that just doesn't work we have to go out and see them. We have to make sure that they can pick up their medication all of those things. So, we were 100% field-based the whole time even last summer through the fires at the same time, the civil unrest. I am really proud of what we did last year." – BACS

Asian Health Services had started tele-psychiatry appointments prior to the pandemic and Tri-City, Valley, and Eden have emergency medication clinics so they also had the equipment for telepsychiatry prior to the start of the pandemic.

"We actually started our psychiatry clinic on a pilot, and we worked with Henning and the adult service team to start that. That actually started in November of 2019 so the fall/winter 2019 so we were starting to pilot it. And then of course the pandemic hit you know sometime in March, and we were just able to convert not just psychiatry team pretty much our entire staff to telehealth. And that really helped us to continue providing care to our clients and also maintain or increase our visit rates through telehealth." – Asian Health

Telehealth Definition

Programs implemented telehealth differently and tele-psychiatry was different than tele-case management. Below are the different ways that telehealth was implemented.

Program Name	Tele-psychiatry	Tele-case management
Asian Health Services	Come into office for services via Zoom.	Depending on severity. Zoom or telephone.
Tri-City	Phone calls or virtual meetings, which could happen in office.	Phone calls or virtual meetings but would meet clients outside or in office when they preferred.
Valley	Phone calls or virtual meetings, which could happen in office.	Phone calls or virtual meetings but would meet clients outside or in office when they preferred.
La Clinica	Combination of phone and video services. Criteria of who needs in-person appointments is usually those on long-acting injectables.	Combination of phone and video services.
Oakland	Facilitated via Case Managers in field with laptops or they can come into the office.	None, still field based.
West Oakland	Telephone	Telephone with some preferring to come into office.
Bonita	None. Stayed in field and did injections.	Telephone
Eden	Virtual and arrangements with some case managers, but no uniform process.	Telephone
BACS	Used client phones or case managers facilitate through laptops on car dashboards.	Telephone for a few weeks but then they went back out in the field.
Felton	Some telehealth happening, but based off clinical triage of whether a service is necessary and safe to be in person.	Some telehealth happening, but based off clinical triage of whether a service is necessary and safe to be in person.
La Familia	Phone calls either with client phones or facilitated with case manager.	Phone calls, but also quickly back in the field.
Telecare	Mostly on intake and combination of phone and video. Then see them in person.	Phone versus in person was based on Alameda County's COVID-19 numbers.

Client Responses to Telehealth

Overall clients struggled with the tele-case management but did better with tele-psychiatry because that was often facilitated by the case managers either in cars using laptops/smartphones or by clients coming into the office. Often the struggle was that clients did not have the resources to use virtual platforms.

"I would say it wasn't happening a ton and I think that is sort of clientele, do they have a phone? Do they have a smartphone? Most of them probably don't. Some of them have computers, but I would say for the most part most of them do not. Are they somewhere with their phone with Wi-Fi access? Is the other piece. So, I would say that the telehealth was a big barrier with our clients at least. I think we can catch them on the phone, but maybe not necessarily telehealth." – Telecare

Phone calls are hard for clients, too, because they can be hard to get ahold of due to not having phones, their phones get shut off, or if they are paranoid about people listening to their conversations.

"Some of our clients are actively symptomatic so if you have a delusion that people are listening in on your conversation then you probably don't want to be on the telephone. Some of them just aren't talkative and things of that nature so it just very hard to be on the phone having a conversation with great fluidity." – Eden

Two of the programs, La Clinica and BACS, mentioned using staff time to do technical skill building with clients.

"We enlisted our peers and our MHRS to help us help contact our participants and we enlisted their help and helping build technological skills to walk someone through how to download an app or walk them through how to log on to Wi-Fi or whatever those resources were. We really had to divert a lot of staffing to help people build the capacity to engage in services." – La Clinica

Telepsychiatry went better because it was often facilitated by staff in the field or when a client came into the office to use the rooms that were set up for tele-psychiatry.

"We have either iPhones or our laptops and so we can do that in the field…[or] they prefer to come in. So, when they come in we have laptops set up in the doc offices so they can do their Telehealth and we have everything set for them the case manager can still supervise but be at least 12 feet away just to make sure that the case manager can supervise but is still socially distant." – Oakland

Staff Responses to Telehealth

The Program Managers think the psychiatrists like the telehealth model overall and it does make it easier to keep clients on medicine, but most of the Program Managers think at least occasional in-person visits would be useful:

"I don't know how I feel about that because I do feel like it's important for the psychiatrist to at least lay eyes on them every now and again. What you see face-to-face it's different than what you hear over the phone. So, I have to think more about that and probably talk to them about where they are with that, but I do want to move back to at least once every 6 months you have a face-to-face visit with somebody depending on how frequently you're meeting with them. That you see them at least once a year or once every 6 months." – West Oakland

"I think there should be that as a choice for clients because they were never given a choice with the psychiatrist. They had to be seen face-to-face or they wouldn't get a refill so that was very difficult so that's been easier and the clients like that." - Tri-City and Valley

Areas for Change or Improvement

Program Activities to Streamline or Change

Due to move to MHSA-funding program activities were asked about streamlining or changing, staffing adjustments they would make, what pandemic-related changes they would like to keep, and what success looks like for these clients.

Clinical Documentation

All of the Program Managers mentioned the burden of documentation and had varying ideas for how to decrease the burden. Including decreasing how often assessments need to be done:

> *"But I think just how frequently we have to do our annuals. We do them annually. I know other counties are moving towards a two-year review instead of a one-year review. I think that is something that could be helpful." – Asian Health Services*

Having the paperwork requirements be less stringent and more like high-level requirements:

> *"I would attempt to reduce the quality assurance regulations and have them be more on parity with other federal or state requirements so they're not too exhaustive." – La Clinica*

A couple of the program managers suggests that technology should be leveraged to help decrease the burden and duplication of information:

> *"In general, I think if there was some way, we could figure out how to streamline the paperwork I think having a medical record that pulled information from different areas so that you're not reinventing the wheel every time you open a new document." – Tri-City and Valley*

> *"I don't know if this is across the board what Almeda County does, but it sounds like there's three separate things you have to do and you have to fill out the clinical assessment form, you have to log into a separate thing and fill out the ANSA, and then you have to do another form which is a screening questionnaire through Alameda County Behavioral Healthcare where it's like "Do they meet the medical necessity?" So, if I'm understanding it correctly there's actually three forms you have to do which within the San Francisco programs we have it all embedded in one form." – Felton*

Telehealth

Due to the pandemic programs were able to try telepsychiatry and tele-case management, most of the Program Managers expressed that they would like to keep some version of telehealth. However, for some agencies, like BACS they were explicit that they only wanted to keep it for psychiatry, while others like Felton are using remote telehealth technology to help with the workload of their licensed clinical case managers.

> *"One thing we're doing right now we just brought over a couple of tablets to support because we are understaffed, we're using the tablets with the peer counselors to connect back to the clinical staff that are at the office writing the assessments and treatment plans to kind of be more efficient with the time and to be able to connect with the clients directly." – Felton*

> *"I think like depending on what's going on with an intake client I think maybe the psychiatrist doing them virtually might be easier. And they can get it done quicker. So then again because historically the intakes would just come into our office, which they are more than welcome to do at this point. And I'm always the person who feels like in person is better. But I also recognize that if they were at Jay Mahler or something that going to get them to bring them all*

the way to the office is very disruptive to their day as well. So, in certain situations, I feel like that could be something that could continue for the better." – Telecare

However, case managers going back into the field and the psychiatrist at least occasionally seeing the clients in person was important.

"But I do think at a certain point it's going to be like, "Everything's open so take your mask if you don't feel comfortable. You can ask your client to take a mask." …We've been doing vaccinations here and I know they're quite a few of our clients have gotten vaccinated here so that helps." – West Oakland

Remote Work

Keeping remote work for case managers to be able to do administrative or paperwork was something that a few agencies want to keep and found useful during the pandemic (Tri-City, Valley, and Bonita House).

"I think as a team we'll keep the sort of I think we'll move into more of a hybrid model where as much of the work with clients as possible that can be done see face-to-face will be done face to face. But I think that there will be a lot less utilization of the office. Particularly for administrative tasks, things like documentation and that sort of thing will be something that folks will have the ability to do at home if they would like." – Bonita House

While programs are fine with some remote administrative work not every program wants to keep 100% remote work (West Oakland and Eden) because some clients want to come into the office.

"So, now that things have calmed down I said, "Everybody needs to be in at least 3 days a week" and people can do whatever configuration they want but you should be here more in the office. Because what happens is some of our clients do come and they might not come on the day that their provider is here because they just pop up. and it's been fine because the other providers that are here will work with them and help them get whatever it is they need but I think it's better when they're able to meet with their actual provider." – West Oakland

Additionally, remote administration meetings between ACBH and the teams was seen as useful and time saving.

"I do think that for some of the meetings with like not with just our team but with Administration as a whole I used to go down to the Cove but now they've all been move to go to meetings or Microsoft Teams and it's actually freed up or time that I can spend doing stuff here but I don't have to have all the commute time." - Oakland

Separate Substitute Payee from Clinical Relationship

How the Substitute Payee program affects clinical relationships was also a concern for three of the program, Oakland, Telecare, and West Oakland Health Council.

"I would totally disconnect the sub-payee from their Mental Health Services because it creates a lot of work that we don't get reimbursed for and then dealing with you know we have clients some of whom are quite paranoid and our providers have to deal with, "You're taking my money. I know you are" or you know if you have somebody who's homeless and trying to get them to keep their receipts for the check they just last requested. It takes up a lot more time than I think the county understands." – West Oakland

Increasing use of Peer/Group Supports

One of the impacts of COVID and even before COVID the use of peer or group support work was not as robust as program managers would like it to be. Specifically, being able to be compensated for group care was mentioned (La Clinica).

> *"I don't know if we could or couldn't change this but one of the things that we've done in San Francisco that I really appreciated is you know we've held groups and we developed a program specifically which was just an older adult day Support Center. So, a little bit of a shifting of the model to group level work because I do often see the work that we do as individually based here in Alameda County so I do see one person doing one thing with one person. I think the benefit to doing it is that we get our clients as they feel comfortable around each other and to develop their own peer base as well." – Felton*

> *"If I could fix anything I would make it that we could have in-person indoor groups again." – Oakland*

Staffing Changes and Improvements

Increase Staffing and Adjustments

Increase staffing in various areas was mentioned the most often with increasing the number of master's-level staff being mentioned more often. Seven program managers representing 8 agencies mentioned this.

> *"I would probably just bring on more case management staff. I would like to have the capacity for individuals to really live their passion and do the specialty work because many of them are skilled and or certified in different modalities but because we are primarily case managers the therapeutic modality that takes a back seat to everything else." - Eden*

The second most often mentioned expansion of staff was for peer staff, which was mentioned by 4 agencies.

> *"I would like to broaden the availability of sort of peer focused and peer-led services I think that the peer initiative has kind of been on pause for a few years. It would be nice to see those activated again and as well as the family partner role being expanded a little bit more." - La Clinica*

Having nursing staff as part of the team was mentioned by three agencies.

> *"That's really a pie in the sky Idea. ICM has never had a nurse. One of the things that I would say that is pretty true for all the clients we have is that they have major medical issues and many, many of them do not like the doctor's and it's been really tough this last year. ... A nurse can do a number of things they can give injectable anti-psychotics in the field for people that are not quite able to get to a clinic, they can troubleshoot in the field, when a client has some sort of problem that they don't want to go to the ER or they don't want to go to their primary care doctor. ...Field-based nurses would be amazing." - BACS*

Finally, having a housing coordinator with money to help was the last type of staff member that wanted to be increased with two program mangers representing three agencies mentioned this.

> *"A lot of people want to live independently in an apartment with Section 8. But it takes a tremendous amount of paperwork and a tremendous amount of coordination to get somebody into subsidized housing. It would be nice if the county would commit to improving some of the*

Board and Care Homes. They have the HSP, the housing support program, but what ends up happening is that the people who are really problematic and really severe can't get into those programs because they're too sick and they can pick and choose because they're always full. So, they end up going into the crappier homes because they'll say yes. So, it's that whole dynamic I think that's a huge weakness because the housing situation really help stabilize people."- Tri-City and Valley

Data Collection Areas of Improvements and Needs

Even though there is a lot of data that ACBH collects and shares Program Managers still mentioned areas where they would like to see improvement.

Improve Information on New Referrals

Many (Eden, Bonita, Tri-City, Valley, and La Familia) program managers expressed concern over the depth and breadth of the information provided when they receive a new referral to their team. All referrals are process through ACBH's ACCESS line and one program manager stated that:

"We have situations where individuals have forensic background and pretty violent histories and if we're not taking the time to really dig deep into some of the files we're putting some of our case managers at risk… In the olden days probably from 2010 to 2015/2016 they were much better at giving us additional information but again their system was set up a little differently…I think that the ability for them to ACCESS and to give us the background information because I think sometimes they give to us and they don't appear to meet medical necessity but somebody has made an administrative decision, which we understand so then we have to spin our wheels trying to figure out why I received this referral and/or trying to assess to find out what criteria has actually been met for them to receive services." – Eden

Comparison Dashboards

While there was not consensus over what should be shared between the Service Teams, some of the Program Managers are curious about how the other Service Teams are doing.

"I think something new that the service teams have started to share amongst each other is utilization data. I think that's been really useful to understand you know what is the overall need / burden on the system and how are each of the service team sort of holding that burden. I think that's been useful for helping us understand each other's work and barriers. I think that if there was a little bit more open us our visibility into the inpatient utilization I know acute care coordination helps to serve that but I think it's a little less quantitative then I would like." – La Clinica

System Challenges

In addition to the Service Team specific program, staffing, and data needs that the Program Managers mentioned they also spoke about staffing and program challenges that are seen system-wide.

Hiring and Staff Retention

The system-wide problem of hiring and staff retention difficulties has also affected the Service Teams. The Program Managers of Asian Health Services, Telecare, Tri-City and Valley, La Clinica, Bonita House, BACS, and Felton mentioned hiring and retention difficulties of staff and psychiatrists. Additionally, Telecare, La Clinica, Bonita House, and Felton mentioned staff turnover as a challenge to their program during the pandemic.

"We've had a really hard time recruiting in general. I think part of it is that the salaries are on the lower end for the CBOs and are significantly below Kaiser. So, just recruiting anybody that has a

Master's and is willing to take the pay that is offered has been a challenge. It has not been easy to find MHRS that are non-master's or even adjunct we've had open positions. We've had at least one open position my entire tenure and there are not lots of applicants and most of the individuals we've interviewed we've hired. Whether they've chosen to come to us or not is a different story. We've had a really sort of tough go a number of folks on our staff have left the state in the middle of COVID and just decided that they're moving and that they're done with California. Sort of making big life decisions. So, recruiting has been really hard in general." – Bonita House

"I think a team-level weakness is that there's a lot of turnover in staffing of availability to address the needs of persistently mentally ill adults that are both linguistically and culturally responsive. I think there is a lack of consistent pipeline programs that help us do that staffing at least at the graduate training level and there is a real lack of extending the loan repayment to graduate-level mental health providers that exist to let primary care providers who are meeting shortage area gaps. Those are real weaknesses that contribute our staffing shortages." – La Clinica

Need for More Clients

La Familia and West Oakland Health Council reported not having enough clients for their team. This is a system challenge because referrals come through ACCESS for specialty mental health clients.

"I would say one of the weaknesses is, not so much the arrangement, but it's hard to give the clinicians a full caseload at times because there's not enough clients. That's all I can really think of." – La Familia

"Truthfully right now we don't have enough clients right now to expand. We're contracted for six positions for the Adult Services but because we are not billing enough and we didn't have enough clients we put one of those roles on hold." – West Oakland Health Council

Resources Agencies Want and Need

Housing

In addition to staff to navigate housing for clients as part of the teams, many Service Teams mentioned the general need for more housing and the ability to access emergency housing.

"The unfortunate part is because we're in the Bay Area and there's the housing crisis it takes a long time and they are understandably ranked [to access housing]. But people staying in these with, lack of a better word, kind of gross unlicensed board and cares for $850 a month. Where they get hot dogs or peanut butter and jelly sandwiches during the day. It's like nobody wants to do that, understandably and they're choosing most the time between that and homelessness." – Telecare

Transportation

Transportation for medical appointments that are an alternative to paratransit and case managers picking clients up was also mentioned. Telecare, La Familia, Tri-City, Valley, La Clinica, and Felton, which said they need a new agency vehicle, all spoke about transportation needs.

"Sometimes you need a clinical person in there to get the person to even go you know, cuz you're like supporting them or helping them in their anxiety or making sure that information is conveyed to the provider once they get to an appointment. But sometimes you just need a little bit of that and it's mostly driving so it'd be nice if we had some more options for a supportive transportation situation. The county has tried different things over the years but you know it is a little expensive to be paying a master's-level person to be driving." – Tri-City and Valley

Day Programs or Groups

Many programs wanted access to structured day programs or other groups, La Familia, Tri-City, Valley, La Clinica, Oakland, West Oakland, spoke about wanting this resource. While there are the Wellness Centers, a lot of the programs said that their staff or their clients did not think they provided sufficient services.

> *"I would like to see, like I said earlier, day programs is something that we're starving for in the model of the Villa Fairmont Day program that they have it is just such a good model. I'd love to see that for our Medi-Cal clients or something similar…So, they have groups specifically for clients with psychotic symptoms and that's really nice. They have really nice group activities like art and music. Things better pretty enriching for someone's life and makes them feel like they're doing something a lot of our clients I wish I could offer them that but if they don't have Medicare they can't use that program." – La Familia*

> *"Yes, because a lot of times our clients don't do well in general population groups. And part of the way that the county is trying to deal with that was with the wellness centers. But for whatever reason our clients haven't they haven't been as popular as we had hope. Let's put it that way and then the pandemic just wiped them out." – Tri-City and Valley*

More in-language services

Along the lines of needing day programs other services teams that provide in-language services often have a need to be able to refer patients to other levels of care and can feel constrained doing so because of the limited in-language services.

> *"I know sometimes there are wellness centers in areas where folks can go in the county for support. If there are areas that can provide that that are in language for our clients, we would prefer them to go there to get support and to engage with others during the daytime. I think that is something that could be helpful. Definitely more funding and resources for language services. We do use the county-provided interpretation line, which is helpful but of course there are other times when an in-person interpreter is also useful and helpful. So, just having something available for that for our population. I mentioned earlier too just more in language support in the higher level of care. It can be more supportive environment for the clients. That would be useful, too." – Asian Health*

Funding for Incentives

Some (La Familia, West Oakland, BACS) of the Services teams would like money for gift cards, bus tickets or other flex funds to help their clients.

> *"For some of our clients transportation is an issue so if we could give them bus tickets that would be great. Some of our clients are homeless and may not be on SSI so don't really have any money so like a gift card to a grocery store so that they get some basic needs met that would be great. I think those two tied together would help."- West Oakland Health Council*

Dementia Care

The only Service Team that serves only older adults, Felton, mentioned a unique need for that age groups, which was dementia care.

> *"Right like you can't therapy somebody out of dementia. You're not going to antipsychotic medications I'm out of dementia. We really need significant, significant services across the board, across the country we don't have adequate services for those needs. And they really require a different kind of wrap-around team like a different kind of frequency of visiting. Once*

a week doesn't cut it for someone who's really symptomatic and not in supportive enough housing that really becomes their needs really become 24/7." - Felton

Program Recommendations

While there are many system-wide challenges that emerged from the Program Managers, these recommendations focus on the Service Teams.

1. Define Client Success:

   Since there is not a single definition of success, then the Service Teams and ACBH are often focused on symptom reduction and not whether "anyone is better off". This leads to clients that may not need the Service Teams to continue to receive intense services without being graduated to a lower-level of care. One possible foundational theory for success is the Basic Psychological Needs Theory (BPNT):

   > *"The theory also proposes that all humans have three basic psychological needs, or experiential requirements, whose procurement supports intrinsic motivation, growth and health just as the procurement of basic physical requirements supports the growth and health of plants. The three needs are:* ***autonomy (needing to be self-regulating; to own one's actions and to identify one's self with one's behavior); competence (needing to be effective; to be moving towards greater mastery and skill); and relatedness (needing to feel psychological connection with important others; to support, and be supported by, those others)****."*[2] *[emphasis added]*

   This theory is one of six mini-theories within the framework of Self-Determination Theory. The concepts of autonomy, competence, and relatedness map to what the Service Team Program Managers described when asked "what success looks like for their clients." Additionally,

   > *"contexts that support versus thwart these needs should invariantly impact wellness. The theory argues that all three needs are essential and that if any is thwarted there will be distinct functional costs."*[3]

2. Measure Client Success:

   Once success is defined then exploring measure that are already collected or need to be collected. This could include the Mental Health Statistics Improvement Project (MHSIP), which Service Teams are already asked to collect from their clients.

3. Explore alternative staffing models and the use of Telehealth:

   In order to transform the Service Teams as required by their move to MHSA funding, then implementing the innovative staffing pattern. For instance, Oakland Community Support, utilizes an Engagement Team to provide intensive outreach to engage new clients, this critical service is not always billable under Medi-Cal. Additionally, this

[2] From: Sheldon, Kennon M. (2012) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3363380/
[3] From: Vensteenkiest, Maarten; Ryan, Richard M.; & Soenens, Bart (2020) https://link.springer.com/article/10.1007/s11031-019-09818-1

model allows the rest of the team members to then focus on the day-to-day needs and treatment of securely engaged clients. Another model to consider is the team approach employed by the assertive community treatment (ACT) teams. With this model, the client works with the whole team. This empirically proven model assures the whole team is aware of each client's treatment needs and that clients have real time access to care even if their lead clinician is out of the office or busy providing services to another beneficiary. Implementing an ACT model would institutionalize the collaborative approach that many Program Managers already see as a strength of their Service Teams.

The use of Telehealth could also be useful and more convenient for more stable clients. It could reduce transportation barriers to treatment and help leverage clinician capacity by decreasing client transportation time. Clinicians can see beneficiaries in their home via Telehealth or visit them in the home and support a Telehealth psychiatric visit. This could increase the client's overall support and contact rate with their clinical team.

4. Expand Internships Programs to all Service Teams:

   The need for more clinical staff is needed across the whole ACBH system. One of the ways to reduce some of the current burden and to develop future clinicians to expand the workforce is through internship programs. The interns could do similar work to what the BACS interns are doing, which is the initial intake and treatment planning.

alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

MENTAL HEALTH SERVICES ACT (MHSA)

STAKEHOLDER GROUP MEETING CALENDAR, 2022 rv1

** This schedule is subject to change. Please view the MHSA website for calendar updates.

DATE	TIME	LOCATION	MEETING THEMES
January 28, 2022	2:00-4:00pm	Go To Meeting	• Program Spotlight: Mental Health Peer Coach • Annual Plan Update • MHSA Community Planning Meetings (CPM) Outreach & Focus Group
February 25, 2021	2:00-4:00pm	Go To Meeting	• MHSA Goal Setting/Finding A Common Link • INN recommendations • Review Operating Guidelines
March 25, 2022	2:00-4:00pm	GoToMeeting	• Program Spotlight: FSP (Strides)
April 22, 2022	2:00-4:00pm	Go To Meeting	• Program Spotlight: Supportive Housing
May 27, 2022	2:00-4:00pm	GoToMeeting	• MHSA Plan Public Comment/Public Hearing • Quarterly Program Data Review •
June 24, 2022	2:00-4:00pm	Go To Meeting	• Compliance- HIPAA for family members
July 22, 2022	2:00-4:00pm	Go To Meeting	• Leg Review: AB2022
August 26, 2022			• Program Spotlight: Deaf & Hard of Hearing
September 23, 2022	2:00-4:00pm	Go To Meeting	• Program Spotlight: Annual Plan Review & CPPP Data
October 28, 2022	2:00-4:00pm	Go To Meeting	• Leg Information: Conservatorship
November 18, 2022**	2:00-4:00pm	Go To Meeting	• Review demographic info for alameda county
December 16, 2022**			• Program Spotlight/Presentation: • MHSA Policy & Legislation Review • End of Year Celebration/Retreat • Interview Qs